

Gennrich, Jane

From: Eide, Tamara J.
Sent: Thursday, November 03, 2016 10:18 AM
To: Gennrich, Jane
Subject: FW: Epilepsy Drugs Annual Update for Idaho P&T

Tami Eide, Pharm.D., BCPS

Medicaid Pharmacy Program Supervisor/Manager Idaho Department of Health and Welfare eidet@dhw.idaho.gov
3232 Elder St.
Boise, ID 83705
208-364-1829
800-327-5541 fax

-----Original Message-----

From: Robert Wechsler [<mailto:wechsler5@me.com>]
Sent: Wednesday, October 12, 2016 7:59 PM
To: Eide, Tamara J.
Subject: Epilepsy Drugs Annual Update for Idaho P&T

Hi Tami,

Looks like time got away from us again this year and I understand the AED's are coming up for review again.

I want to thank you guys again for being so easy to work. Having collected some of the most complex epilepsy patients in the state, it is very helpful to be able to work proactively with payers to make sure patients have good therapeutic options.

For what they are worth, I'm including my thoughts below (some copy-paste from last year's email, but with some new information added). I will do my best to try to be there on 11/18 but rather than testify, maybe I can make myself available to answer any AED questions folks might have?

I'm going to include the new stuff in the first couple of paragraphs and put the re-hash stuff below that.

NEW: The new drug in the epilepsy world is Briviact, an SV2A drug that has similar mechanism of action to levetiracetam but is more specific because it has a much higher binding affinity for SV2A. While they do not have direct comparative data, my hunch is that Briviact will turn out to be better tolerated than levetiracetam due to that higher binding affinity and maybe slightly better efficacy - in their clinical trials patients who failed levetiracetam still sometimes were helped by Briviact, so the two drugs are not interchangeable.

NEW, but less new: Fycompa now has an oral suspension. This drug has panned out well for some patients and I am starting to think some of the behavioral problems in the box warning are not as prominent as advertised, now that I have a few dozen patients on it. The drug does have a few unique aspects. It has a unique mechanism of action, so it is a great add-on to just about anything. It also has a very long half life (105 hours), so it is a legitimate once-daily drug and great for those who often forget medicines. It is approved for primary generalized tonic-clonic seizures in addition to all focal seizures, which is really great because we have 24 drugs to choose from in epilepsy but only 6 of them are commonly used in generalized epilepsy and some of the others can make generalized epilepsy worse.

Older Thoughts:

My treatment choices remain more focused on mechanisms of action - we never use two beta blockers in combination or two penicillins, so why would we use two different sodium channel drugs or two different GABA drugs in epilepsy? So I really prefer to use drugs with different mechanisms when I have to use combination therapy. Also, I remain a strong proponent of seizure meds that can be taken once a day, at night, so folks can get the worst of their side effects over with while asleep in bed. Sadly, a lot of our epilepsy drugs still have dose dependent side effects that make the morning doses troublesome for active people.

I am having good success still with Vimpat and levetiracetam, both are easy to use and relatively well tolerated. The extended release levetiracetam is a good twice a day drug but really does not carry over well enough for once a day in a lot of patients. So I use levetiracetam and switch to extended release for those folks who have end-of-dose seizures with the regular stuff. These are pretty much my first line drugs at this point, although Aptiom also is a good fit there if they have not already failed carbamazepine or oxcarbazepine (many of the patients I see have tried these before getting to me). I still prefer Aptiom over carbamazepine, oxcarbazepine, or phenytoin for sodium channel drugs. I also prefer it to extended release oxcarbazepine because Aptiom can be cut or crushed whereas the extended release oxcarbazepine has to be taken whole.

We have several good drugs for second line or add-on due to the fact that they require slow titration - lamotrigine, topiramate, zonisamide, Fycompa. All have unique advantages. Lamotrigine is great if they have comorbid depression. Topiramate or zonisamide if they have comorbid migraine. Fycompa, as above.

I still like extended release topiramate. I think that Quedexy and the generic topiramate ER are superior to Trokendi XR and to regular topiramate because it can be taken once daily even if used as a sprinkle for those who cannot swallow. Trokendi XR cannot be used as sprinkle and regular topiramate sprinkles only come in 25 mg capsules (so one topiramate ER 200 mg capsule taken once daily can replace 8 25 mg topiramate sprinkle capsules being divided BID).

We are using lots of Onfi both on and off label. It seems to be less sedating and less prone to tolerance than the older benzos and also has a long half-life, so can be safely used once daily. The publication I told you about regarding possibly less tolerance with Onfi will be published in Neurology in a few weeks.

Divalproex ER remains the best of the valproate forms and still has an important role for generalized epilepsy but is pregnancy class X, so a serious concern in women.

Banzel has helped with some Lennox-Gastaut patients but I have not had much luck with it outside of those cases.

I am definitely using less gabapentin, Lyrica, and Gabitril for epilepsy, mostly because of frequency of dosing and tolerability issues at effective doses.

Carbamazepine, oxcarbazepine, gabapentin and Lyrica do play important roles in various pain syndromes.

Felbamate, Sabril, Potiga, phenobarbital are definitely bottom of the barrel due to safety and tolerability concerns. In fact, Potiga is being discontinued.

The new vagus nerve stimulator (model 106) has an automatic seizure detection and rescue feature that makes it very attractive in those focal cases where brain surgery is not an option. RNS also will have a roll in those cases but is fairly invasive, so not likely to be used much - two patients so far in Idaho, with one or two more in the works. VNS is implanted in Boise, RNS has to be implanted in Seattle or Los Angeles. I am the only physician in the state trained in the programming of RNS.

Hope that helps!

Best Regards,

Robert T. Wechsler, MD, PhD, FAAN

Owner, Consultants in Epilepsy & Neurology, PLLC Medical Director, Idaho Comprehensive Epilepsy Center

1499 West Hays St., Boise ID 83702

phone (208) 275-8585

fax (208) 275-8586