Clinical Policy: Clobazam (Onfi, Sympazan)

Reference Number: DE.PMN.54
Effective Date: 01.23
Last Review Date: 01.23
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Clobazam (Onfi®, Sympazan®) is a benzodiazepine.

FDA Approved Indication(s)
Onfi and Sympazan are indicated for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome (LGS) in patients 2 years of age or older.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Onfi and Sympazan are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Lennox-Gastaut Syndrome (must meet all)**:**

1. Diagnosis of LGS;
2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 2 years;
4. For Sympazan requests, failure of an adequate trial of at least two preferred* FDA-approved drugs for the indication and/or drugs that are considered the standard of care within the same drug class on the PDL, when such agents exist, at maximum indicated doses, unless clinically significant adverse effect are experienced, or all are contraindicated;
   **Generic is preferred, if available, and brand is not the preferred agent*
5. For Onfi and Sympazan requests, member must use generic clobazam tablets or oral suspension, unless clinically significant adverse effects are experienced or both are contraindicated;
6. Dose does not exceed both of the following (a and b):
   a. 40 mg per day;
   b. 2 tablets per day, 16 mL per day, or 2 films per day.

Approval duration:
Medicaid – 12 months

B. Intractable/Refractory Epilepsy (off-label) (must meet all)**:**

1. Diagnosis of intractable/refractory epilepsy;
2. Prescribed by or in consultation with a neurologist;

3. Age ≥ 2 years;
4. Failure of ≥ 2 anti-seizure drugs (*see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;
5. For Onfi and Sympazan requests, member must use generic clobazam tablets or oral suspension, unless clinically significant adverse effects are experienced or both are contraindicated;
6. Dose does not exceed both of the following (a and b):
   a. 40 mg per day;
   b. 2 tablets per day, 16 mL per day, or 2 films per day.

Approval duration:
Medicaid - 12 months

C. Dravet Syndrome (off-label) (must meet all)**:**
1. Diagnosis of Dravet syndrome;
2. Prescribed by or in consultation with a neurologist;
3. Age ≥ 2 years;
4. For Onfi and Sympazan requests, member must use generic clobazam tablets or oral suspension, unless clinically significant adverse effects are experienced or both are contraindicated;
5. Dose does not exceed 2 mg/kg per day.

Approval duration:
Medicaid – 12 months

D. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Onfi or Sympazan for a covered indication and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed one of the following (a or b):
   a. LGS or intractable/refractory epilepsy – both of the following (i and ii):
      i. 40 mg per day
      ii. 2 tablets per day, 16 mL per day, or 2 films per day;
   b. Dravet syndrome: 2 mg/kg per day.

Approval duration:
Medicaid – 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
LGS: Lennox-Gastaut syndrome

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Anticonvulsants-benzodiazepines		
clonazepam (Klonopin®)	See full prescribing information	See full prescribing information
diazepam rectal gel (Diastat®)		
Carbamates		
felbamate (Felbatol®)	See full prescribing information	See full prescribing information
GABA modulators		
vigabatrin (Sabril®)	See full prescribing information	See full prescribing information
tiagabine (Gabitril®)		
Hydantoins		
Peganone® (ethotoin)	See full prescribing information	See full prescribing information
phenytoin (Dilantin®)		
Succinimides		
ethosuximide (Zarontin®)	See full prescribing information	See full prescribing information
Celontin® (methsuximide)		
Valproic acid		
divalproex sodium (Depakote®)	See full prescribing information	See full prescribing information
valproic acid (Depakene®)		
AMPA glutamate receptor antagonists		
Fycompa® (perampanel)	See full prescribing information	See full prescribing information
Anticonvulsants-miscellaneous		
Briviact® [brivaracetam], carbamazepine [Tegretol®,	See full prescribing information	See full prescribing information

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Tegretol XL®], Aptiom® [eslicarbazepine], Potiga® [ezogabine], gabapentin [Neurontin®], Vimpat® [lacosamide], lamotrigine [Lamictal®], levetiracetam [Keppra®, Spritam®], oxcarbazepine [Oxtellar XR®, Trileptal®], Lyrica® [pregabalin], primidone [Mysoline®], Banzel® [rufinamide], topiramate [Topamax®, Qudexy XR®, Trokendi XR®], zonisamide [Zonegran®])		

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): history of hypersensitivity to the drug or its ingredients
- Boxed warning(s): risks from concomitant use with opioids; abuse, misuse, and addiction; dependence and withdrawal reactions

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
LGS	Patients ≤ 30 kg body weight: initiate at 5 mg PO daily and titrate as tolerated up to 20 mg daily Patients > 30 kg body weight: initiate at 10 mg PO daily and titrate as tolerated up to 40 mg daily A daily dose greater than 5 mg should be administered in divided doses twice daily; a 5 mg daily dose can be administered as a single dose.	≤ 30 kg body weight: 20 mg/day > 30 kg body weight: 40 mg/day
Intractable/refractory epilepsy (off-label)	See LGS	See LGS
Dravet syndrome (off-label)	Initial: 0.2-0.3 mg/kg/day PO Maximum: 0.5-2 mg/kg/day PO	See regimen

VI. Product Availability

Drug Name	Availability
Clobazam (Onfi)	Tablet with a functional score: 10 mg, 20 mg Oral suspension: 2.5 mg/mL in 120 mL bottles

Drug Name	Availability
Clobazam (Sympazan)	Oral film: 5 mg, 10 mg, 20 mg

VII. References

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	11.22	01.23

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members

and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.