AETNA BETTER HEALTH®
Coverage Policy/Guideline

Name:	Clobazam, Sympazan	Page:	1 of 2
Effective Date:	8/5/2024	Last Review Date:	7/2024

Applies to:	☐Illinois	☐Florida	☒Florida Kids
	☒New Jersey	☐Maryland	☐Michigan
	☒Pennsylvania Kids	☐Virginia	☐Kentucky PRMD

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for clobazam and Sympazan under the patient's prescription drug benefit.

Description:

FDA-approved Indications

Onfi

Onfi (clobazam) is indicated for the adjunctive treatment of seizures associated with Lennox-Gastaut Syndrome (LGS) in patients 2 years of age or older.

Sympazan

Sympazan is indicated for the adjunctive treatment of seizures associated with Lennox-Gastaut Syndrome (LGS) in patients 2 years of age or older.

Compendial Uses

Seizures associated with Dravet Syndrome[3-5]

Applicable Drug List:

Clobazam
Sympazan

Policy/Guideline:

Coverage Criteria

The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for adjunctive treatment of seizures associated with Lennox-Gastaut Syndrome
  AND
  - The patient is 2 years of age or older
    AND
    - The request is NOT for continuation of therapy

    OR
    - The request is for continuation of therapy
      AND
      - The patient has achieved and maintained positive clinical response as evidenced by reduction in frequency or duration of

seizures compared with seizure activity prior to initiation of the requested drug

OR

- The requested drug is being prescribed for the treatment of seizures associated with Dravet Syndrome

  AND

  - The request is NOT for continuation of therapy

  OR

  - The request is for continuation of therapy

    AND

    - The patient has achieved and maintained positive clinical response as evidenced by reduction in frequency or duration of seizures compared with seizure activity prior to initiation of the requested drug

Approval Duration and Quantity Restrictions:

Approval: 12 months

References:

1. Onfi [package insert]. Deerfield, IL: Lundbeck Inc.; January 2023.
2. Sympazan [package insert]. Warren, NJ: Aquestive Therapeutics.; January 2023.
3. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2023. https://online.lexi.com. Accessed April 27th, 2023.
4. Micromedex (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 04/27/2023).
5. Wirrell EC, Hood V, Meskis MA, et. al. International Consensus on Diagnosis and Management of Dravet Syndrome. *Epilepsia* 2022;63:1761-1777.