Clinical Policy: Clobazam (Onfi, Sympazan)

Reference Number: ERX.NPA.124
Effective Date: 12.01.19
Last Review Date: 11.21
Line of Business: Commercial, 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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ 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. Failure of 2 preferred agents for LGS (e.g., clonazepam, valproic acid (divalproex), lamotrigine, topiramate, felbamate), 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 40 mg per day (2 tablets per day, 16 mL per day, or 2 films per day).

Approval duration:
Medicaid – 12 months
Commercial – Length of Benefit

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 ≥ 4 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 40 mg per day (2 tablets per day, 16 mL per day, or 2 films per day).

Approval duration:
Medicaid – 12 months
Commercial – Length of Benefit

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
Commercial – Length of Benefit

D. Other diagnoses/indications
1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions, 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: 40 mg per day (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
Commercial – Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – ERX.PA.01 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 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®, 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®])	See full prescribing information	See full prescribing information

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	≤ 30 kg body weight: 20 mg/day > 30 kg body weight: 40 mg/day

Indication	Dosing Regimen	Maximum Dose
	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.	
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
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	07.25.19	11.19
4Q 2020 annual review: no significant changes; references reviewed and updated.	08.04.20	11.20
4Q 2021 annual review: no significant changes; revised “Medical justification…for clobazam tablets and oral suspension…” to “Member must	08.20.21	11.21

Reviews, Revisions, and Approvals	Date	P&T Approval Date
use clobazam tablets or oral suspension…"; references reviewed and updated.		

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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.