Pharmacy Policy Bulletin: J-0858 Sympazan and Onfi (clobazam) – Commercial and Healthcare Reform	
Number: J-0858	**Category:** Prior Authorization
Line(s) of Business: ☒ Commercial ☒ Healthcare Reform ☐ Medicare	**Benefit(s):** **Commercial:** **Prior Authorization (1. or 2.):** **1.** Sympazan: Miscellaneous Specialty Drugs Oral = Yes w/ Prior Authorization **2.** Onfi: Other Managed Prior Authorization = Yes w/ Prior Authorization **Healthcare Reform:** Not Applicable
Region(s): ☒ All ☐ Delaware ☐ New York ☐ Pennsylvania ☐ West Virginia	**Additional Restriction(s):** None
Version: J-0858-011	**Original Date:** 01/30/2019
Effective Date: 10/08/2025	**Review Date:** 09/17/2025

Drugs Product(s):	• Sympazan (clobazam) oral film • Onfi (clobazam) oral tablets and suspension – *Brand only*
FDA-Approved Indication(s):	• Adjunctive treatment of seizures associated with Lennox-Gastaut syndrome (LGS) in patients 2 years of age or older

Background:	• Clobazam is a benzodiazepine derivative anticonvulsant medication. The mechanism of action is not fully understood; however, it is thought to involve potentiation of GABAergic neurotransmission resulting from binding at the benzodiazepine site of the GABA-A receptor. • LGS is a severe condition characterized by recurrent seizures that begin early in life. Affected individuals have multiple types of seizures, a particular pattern of brain activity (called slow spike-and-wave) measured by an electroencephalogram (EEG), and impaired mental abilities. • Multiple treatment modalities exist for LGS. While not FDA-approved, valproic acid is most often used first line. The American Academy of Neurology (AAN) guidelines currently recommend using topiramate, lamotrigine, rufinamide, felbamate, or clobazam to treat LGS. • Dravet syndrome, formerly known as severe myoclonic epilepsy of infancy (SMEI), is a rare, catastrophic, lifelong form of epilepsy that begins in the first year of life with frequent and prolonged seizures, leading to behavioral and developmental delays. • A 2022 international consensus on diagnosis and management of Dravet syndrome recommends valproate as first line therapy; fenfluramine, stiripentol, or clobazam as second line therapy; pharmaceutical grade cannabidiol as third line; and topiramate or ketogenic diet as fourth line. The following drugs should be

	avoided in Dravet syndrome: carbamazepine, oxcarbazepine, lamotrigine, and phenytoin. • Diacomit (stiripentol) is FDA approved for the treatment of seizures associated with Dravet syndrome in patients taking clobazam who are 6 months of age and older and weighing 7 kg or more. • Onfi (clobazam) is available as a tablet and oral suspension. Onfi oral tablets can be administered whole, broken in half along the score, or crushed and mixed in applesauce. As an oral film that can be taken without water, Sympazan may be preferred by some patients who are severely cognitively impaired or who use feeding tubes. • For members currently stabilized on Onfi or Sympazan or requiring reauthorization of these products, the maintenance criteria should be applied. • Prescribing Considerations: o The member should be under the supervision of a neurologist or epilepsy specialist. o Onfi and Sympazan have black box warnings for risks from concomitant use with opioids, abuse, misuse, addiction, dependence, and withdrawal reactions. o Onfi and Sympazan are schedule IV-controlled substances.

Approval Criteria

I. Initiation

When a benefit, coverage of Onfi or Sympazan may be approved when one (1) of the following criteria are met **(A. or B.):**

A. The member meets all of the following criteria **(1. through 6.):**
- **1.** The member is 2 years of age or older.
- **2.** The member has a diagnosis of seizures due to Lennox-Gastaut syndrome (ICD-10: G40.81).
- **3.** The member will be using Onfi or Sympazan as adjunctive therapy.
- **4.** The member has experienced therapeutic failure, contraindication, or intolerance to at least one (1) standard of care plan-preferred product **(a. through d.):**
  - **a.** valproic acid or divalproex sodium
  - **b.** lamotrigine
  - **c.** topiramate
  - **d.** rufinamide
- **5.** If the request is for Sympazan, the member has experienced therapeutic failure or intolerance to plan-preferred generic clobazam.
- **6.** If the request is for Onfi, the member has experienced therapeutic failure or intolerance to generic clobazam.

B. The member meets all of the following criteria **(1., 2., and 3.):**
- **1.** The member has a diagnosis of Dravet syndrome (ICD-10: G40.83).
- **2.** If the request is for Sympazan, the member has experienced therapeutic failure or intolerance to plan-preferred generic clobazam.
- **3.** If the request is for Onfi, the member has experienced therapeutic failure or intolerance to generic clobazam.

II. Maintenance

When a benefit, coverage of Onfi or Sympazan may be approved when one (1) of the following criteria are met **(A. or B.)**:

A. The member meets all of the following criteria **(1. through 4.):**
- **1.** The member is 2 years of age or older.
- **2.** The member has a diagnosis of seizures due to Lennox-Gastaut syndrome (ICD-10: G40.81).

3. The member is using Onfi or Sympazan as adjunctive treatment.
4. The prescriber attests that the member has experienced a reduction in seizure frequency from baseline.

B. The member meets all of the following criteria **(1. and 2.):**

1. The member has a diagnosis of Dravet syndrome (ICD-10: G40.83).
2. The prescriber attests that the member has experienced a reduction in seizure frequency from baseline.

III. An exception to some or all of the criteria above may be granted for select members and/or circumstances based on state and/or federal regulations.

Limitations of Coverage

I. Coverage of drugs addressed in this policy for disease states outside of the FDA-approved indications should be denied based on the lack of clinical data to support effectiveness and safety in other conditions unless otherwise noted in the approval criteria.

II. For Commercial or HCR members with a closed formulary, a non-formulary product will only be approved if the member meets the criteria for a formulary exception in addition to the criteria outlined within this policy.

Authorization Duration

- Commercial and HCR Plans: If approved, up to a 12 month authorization may be granted.

Automatic Approval Criteria

None

References:

1. Sympazan [package insert]. Warren, NJ: Aquestive Therapeutics; March 2024.
2. Onfi [package insert]. Deerfield, IL: Lundbeck; March 2024.
3. Kanner A, Ashman E, Gloss D, et al. Practice guideline update summary: Efficacy and tolerability of the new antiepileptic drugs II: Treatment-resistant epilepsy. *Neurology*. 2018;91:82-90.
4. U.S. National Library of Medicine. Lennox-Gastaut Syndrome. Available at: https://medlineplus.gov/genetics/condition/lennox-gastaut-syndrome/#causes. Accessed August 12, 2025.
5. NORD. Lennox-Gastaut Syndrome. Available at: https://rarediseases.org/rare-diseases/lennox-gastaut-syndrome/. Accessed August12, 2025.
6. Diacomit [package insert]. Beauvais, France: BICODEX; July 2022.
7. Dravet Syndrome Foundation. What is Dravet Syndrome? Available at: https://www.dravetfoundation.org/what-is-dravet-syndrome/. Accessed June 27, 2023.
8. Epilepsy Foundation. Dravet Syndrome. Available at: https://www.epilepsy.com/learn/types-epilepsy-syndromes/dravet-syndrome. Accessed August12, 2025.
9. Wirrell E, Laux L, Donner E, et al. Optimizing the Diagnosis and Management of Dravet Syndrome: Recommendations from a North American Consensus Panel. *Pediatr Neurol*. 2017;68:18-34.
10. Wirrell E, Hood V, Knupp K, et al. International consensus on diagnosis and management of Dravet syndrome. *Epilepsia*. 2022;63:1761–1777.