Clinical Policy: Clobazam (Onfi, Sympazan)

Reference Number: CP.PMN.54
Effective Date: 11.01.12
Last Review Date: 11.26
Line of Business: Commercial, HIM/ICHRA, 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, Sympazan, and generic clobazam 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. Member meets one of the following (a or b):
   a. Request is for the treatment of a member in a State with limitations on step therapy in certain settings (*see Appendix D*);
   b. 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;*
   **For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395.*
5. For Onfi requests, member must use generic clobazam tablets or oral suspension, unless clinically significant adverse effects are experienced or both are contraindicated;
6. Member meets one of the following (a or b):
   a. Request is for the treatment of a member in a State with limitations on step therapy in certain settings (*see Appendix D*);
   b. For Sympazan requests, member must use generic clobazam tablets or oral suspension, unless clinically significant adverse effects are experienced or both are contraindicated;
7. Dose does not exceed any 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: 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. Member meets one of the following (a or b):
   a. Request is for the treatment of a member in a State with limitations on step therapy in certain settings (*see Appendix D*);
   b. Failure of ≥ 4 anti-seizure drugs (*see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;*
   **For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395.*
5. For Onfi requests, member must use generic clobazam tablets or oral suspension, unless clinically significant adverse effects are experienced or both are contraindicated;
6. Member meets one of the following (a or b):
   a. Request is for the treatment of a member in a State with limitations on step therapy in certain settings (*see Appendix D*);
   b. For Sympazan requests, member must use generic clobazam tablets or oral suspension, unless clinically significant adverse effects are experienced or both are contraindicated;
7. Dose does not exceed any 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: 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: 12 months

D. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or

b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

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 any of the following (a or b):
   a. LGS or intractable/refractory epilepsy – any of the following (i or 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: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

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.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA and CP.PMN.53 for Medicaid, 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		
phenytoin (Dilantin®)	See full prescribing information	See full prescribing information
Succinimides		
ethosuximide (Zarontin®)	See full prescribing information	See full prescribing information
methsuximide (Celontin®)		
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), gabapentin (Neurontin®), lacosamide (Vimpat®), lamotrigine (Lamictal®), levetiracetam (Keppra®, Spritam®), oxcarbazepine (Oxtellar XR®,	See full prescribing information	See full prescribing information

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Trileptal®), pregabalin (Lyrica®), primidone (Mysoline®), rufinamide (Banzel®), 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

Appendix D: States with Limitations against Redirections in Certain Settings

State	Step Therapy Prohibited?	Notes
NV	No	**Applies to Medicaid requests only** • **LGS**: Failure of ONE of the following, unless clinically significant adverse effects are experienced or all are contraindicated: generic clobazam tablets, generic clobazam oral suspension, alternative drug for LGS (e.g., clonazepam, valproic acid (divalproex), lamotrigine, topiramate, felbamate) • **Intractable/refractory epilepsy**: Failure of ONE of the following, unless clinically significant adverse effects are experienced or all are contraindicated: generic clobazam tablets, generic clobazam oral suspension, alternative anti-seizure drug (*see Appendix B*)

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

Indication	Dosing Regimen	Maximum 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
4Q 2022 annual review: no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.	08.25.22	11.22
For LGS and intractable/refractory epilepsy, added redirection bypass for members in a State with limitations on step therapy in certain settings along with Appendix D, which includes Nevada with requirements for single drug redirection for Medicaid requests.	08.31.23	
4Q 2023 annual review: no significant changes; references reviewed and updated.	09.06.23	11.23
4Q 2024 annual review: no significant changes; references reviewed and updated.	07.15.24	11.24
4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.	08.26.25	11.25
4Q 2026 annual review: no significant changes; separated the generic redirection for Onfi from the generic redirection for Sympazan since the Onfi redirection is to a generic equivalent (and thus not subject to the state-specific ST bypass); in Appendix D removed the Medicaid wording on the NV-specific bypass such that the bypass now applies to all NV lines of business; added ICHRA line of business; consolidated the 12-month Initial and Continued Approval durations for multiple lines of business into one statement; references reviewed and updated. Added Medicaid-specific distinction to NV in Appendix D per VPRP request and Compliance.	10.27.26	11.26

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.

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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.

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