Clinical Policy: Diazepam (Libervant, Valtoco)

Reference Number: CP.PMN.216
Effective Date: 12.01.19
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

Diazepam (Libervant™, Valtoco®) is a benzodiazepine.

FDA Approved Indication(s)

Libervant and Valtoco are indicated for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy for the following ages:

- Libervant: 2 to 5 years of age
- Valtoco: 2 years of age and 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 Libervant and Valtoco are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Epilepsy with Seizure Cluster Episodes (must meet all)**:**

1. Diagnosis of partial or generalized epilepsy;
2. Prescribed by or in consultation with a neurologist;
3. Age is one of the following (a or b):
   a. For Libervant: ≥ 2 years and ≤ 5 years;
   b. For Valtoco: ≥ 2 years;
4. Member is experiencing stereotypic episodes of frequent seizure activity (i.e., seizure clusters, acute repetitive seizures);
5. 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 E*);
   b. Currently on a stable regimen of antiepileptic drugs (AEDs) (e.g., lamotrigine, gabapentin, topiramate, oxcarbazepine);*
   **For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395.*
6. Dose does not exceed 2 doses per single episode (not to exceed 1 episode every 5 days or 5 episodes per month) (*refer to section V for age and weight specific dosing*).

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.

II. Continued Therapy

A. Epilepsy with Seizure Cluster Episodes (must meet all)**:**
1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Libervant or Valtoco 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 2 doses per single episode (not to exceed 1 episode every 5 days or 5 episodes per month) (*refer to section V for age and weight specific dosing*).

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
AED: antiepileptic drug
FDA: Food and Drug Administration

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
Examples of AEDs for partial seizures	carbamazepine (Tegretol®), felbamate (Felbatol®), gabapentin (Neurontin®), lamotrigine (Lamictal®), levetiracetam (Keppra®), oxcarbazepine (Trileptal®), phenobarbital, phenytoin (Dilantin®), pregabalin (Lyrica®), tiagabine (Gabitril®), topiramate (Topamax®), valproic acid (Depakene®), divalproex sodium (Depakote®), zonisamide (Zonegran®)	Varies according to the agent used
Examples of AEDs for tonic-clonic seizures	carbamazepine (Tegretol®), lamotrigine (Lamictal®), levetiracetam (Keppra®), phenobarbital, phenytoin (Dilantin®), primidone (Mysoline®), topiramate (Topamax®), valproic acid (Depakene®), divalproex sodium (Depakote®)	Varies according to the agent used

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): acute narrow-angle glaucoma, known hypersensitivity to diazepam
- Boxed warning(s): concomitant use with opioids; abuse, misuse, and addiction; dependence and withdrawal reactions

Appendix D: General Information
- Seizure clusters can be defined as multiple seizures that occur within a short period of time. These seizures will happen in an increased frequency from the patient's normal seizure activity. Thus, they are distinguishable from a person's typical seizure pattern. The definition for a specific time period varies. Various studies use the following time frames: two to four seizures per < 48 hours; 3 seizures per 24 hours; or two generalized tonic-clonic or three complex partial seizures in 4 hours. Seizure clusters are also known as acute-repetitive seizures, serial seizures, crescendo seizures, and seizure flurries, which

highlight the repetitive nature of the seizures. Seizure clusters are a form of seizure emergency that have potential to evolve into prolonged seizures and status epilepticus.

Appendix E: States with Limitations against Redirections in Certain Settings

State	Step Therapy Prohibited?	Notes
NV	No	**Applies to Medicaid requests only** • **Seizures**: Currently on a stable regimen of ONE AED (e.g., lamotrigine, gabapentin, topiramate, oxcarbazepine)

V. Dosage and Administration

<table>
<tr><th>Drug Name</th><th>Dosing Regimen</th><th>Maximum Dose</th></tr>
<tr><td>Libervant (diazepam)</td><td>The recommended dose of Libervant for pediatric patients 2 to 5 years of age is dependent on the patient's weight. The buccal film is applied on the inside of the mouth on top of the surface of the cheek and allowed to dissolve. A second dose, if needed, may be administered at least 4 hours after the first dose.
<table>
<tr><th>Weight (kg)</th><th>Dose (mg)</th></tr>
<tr><td>6-10</td><td>5</td></tr>
<tr><td>11-15</td><td>7.5</td></tr>
<tr><td>16-20</td><td>10</td></tr>
<tr><td>21-25</td><td>12.5</td></tr>
<tr><td>26-30</td><td>15</td></tr>
</table></td><td rowspan="2">2 doses/single episode; do not treat more than 1 episode every 5 days or more than 5 episodes/month</td></tr>
<tr><td>Valtoco (diazepam)</td><td>Spray initial dose* into nostril. If no response 4 hours after the initial dose, a second dose may be given.

*The recommended dose of Valtoco nasal spray is 0.2 mg/kg, 0.3 mg/kg, or 0.5 mg/kg, depending on the patient's age and weight. The following table provides the acceptable weight ranges for each dose and age category.
<table>
<tr><th colspan="4">Dose Based on Age and Weight</th><th colspan="2">Administration</th></tr>
<tr><th>2-5 years (0.5 mg/kg)</th><th>6-11 years (0.3 mg/kg)</th><th>≥ 12 years (0.2 mg/kg)</th><th>Dose (mg)</th><th># of Nasal Spray Devices</th><th># of Sprays</th></tr>
<tr><th colspan="3">Weight (kg)</th><th></th><th></th><th></th></tr>
<tr><td>6-11</td><td>10-18</td><td>14-27</td><td>5</td><td>One 5 mg device</td><td>1 spray in one nostril</td></tr>
<tr><td>12-22</td><td>19-37</td><td>28-50</td><td>10</td><td>One 10 mg device</td><td>1 spray in one nostril</td></tr>
</table></td></tr>
</table>

Drug Name	Dosing Regimen						Maximum Dose
	2-5 years (0.5 mg/kg)	6-11 years (0.3 mg/kg)	≥ 12 years (0.2 mg/kg)	Dose (mg)	# of Nasal Spray Devices	# of Sprays	
	Weight (kg)						
	23-33	38-55	51-75	15	Two 7.5 mg devices	1 spray in each nostril	
		56-74	≥ 76	20	Two 10 mg devices	1 spray in each nostril	

VI. Product Availability

Drug Name	Availability
Libervant (diazepam)	Buccal film: 5 mg, 7.5 mg, 10 mg, 12.5 mg, 15 mg
Valtoco (diazepam)	Nasal spray: 5 mg/0.1 mL, 7.5 mg/0.1 mL, 10 mg/0.1 mL

VII. References

1. Libervant Prescribing Information. Warren, NJ: Aquestive Therapeutics; April 2024. Available at: https://aquestive.com/libervant/. Accessed August 17, 2026.
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4. Kumar A. Complex partial seizure. Available at: https://www.ncbi.nlm.nih.gov/books/NBK519030/. Accessed October 3, 2019.
5. Schachter SC. Seizure clusters. Available at: https://www.epilepsy.com/learn/professionals/refractory-seizures/potentially-remediable-causes/seizure-clusters. Accessed October 3, 2019.
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7. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed May 9, 2024.
8. Pina-Garza JE, Chez M, Cloyd J, et al. Outpatient management of prolonged seizures and seizure clusters to prevent progression to a higher-level emergency: Consensus recommendations of an expert working group. Epileptic Disord. 2024;00:1–14. https://doi.org/10.1002/epd2.20243.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2022 annual review: no significant changes; added the following example for inability to use Diastat: request is for use at school where rectal medications cannot be administered; references reviewed and updated. Template changes applied to other diagnoses/indications.	08.25.22	11.22
Revised "Diastat" to "diazepam rectal gel".	12.08.22	
4Q 2023 annual review: no significant changes; references reviewed and updated.	08.16.23	11.23
RT4: added newly approved Libervant buccal film.	05.08.24	
4Q 2024 annual review: no significant changes; references reviewed and updated.	08.07.24	11.24
Removed redirection to diazepam rectal gel per SDC request.	10.28.24	12.24
RT4: revised Valtoco lower age limit to 2 years and relevant dosing per the updated FDA labeling.	04.23.25	
4Q 2025 annual review: extended initial auth duration from 6 months to 12 months; added redirection bypass for members in a State with limitations on step therapy in certain settings along with Appendix E; 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; in Appendix E 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; references reviewed and updated. Added Medicaid-specific distinction to NV in Appendix E per VPRP request and Compliance.	11.04.26	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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