

PRIOR AUTHORIZATION CRITERIA

DRUG CLASS	ANTICONVULSANTS
BRAND NAME (generic)	ONFI (clobazam)
	SYMPAZAN (clobazam)
Status: CVS Caremark Criteria	
Type: Initial Prior Authorization	

POLICY

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

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 in a patient 2 years of age or older

REFERENCES

1. Onfi [package insert]. Deerfield, IL: Lundbeck Inc.; February 2021.
2. Sympazan [package insert]. Warren, NJ: Aquestive Therapeutics.; August 2020.
3. Lexicomp Online, AHFS DI (Adult and Pediatric) Online, Hudson, Ohio: UpToDate, Inc.; 2021; Accessed May 4, 2021.
4. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: <https://www.micromedexsolutions.com>. Accessed May 4, 2021.