ALASKA MEDICAID
Prior Authorization Criteria

Sympazan™, Onfi® (Clobazam)

Schedule IV Controlled Substance

FDA Indication and Usage:

Adjunctive treatment of seizures associated with Lennox-Gastaut syndrome (LGS) in patients 2 years of age or older

Dosage Form/Strength:

Tablet: 10mg, 20mg
Oral suspension: 2.5 mg/mL in 120mL bottles
Films: 5mg, 10mg, 20 mg

Criteria for Approval:

1. Diagnosis of Lennox-Gastaut Syndrome; **AND**
2. Current therapy with at least one other antiepileptic medication including documentation of current and prior therapies; **AND**
3. Recipient is 2 years of age or older; AND
4. Patient has tried and failed generic clobazam.

Length of Authorization:

- Coverage may be approved for up to 6 months.

Quantity Limit:

- Maximum 2 doses per day (not to exceed 40mg per day).

References:

Onfi® [package insert]. Deerfield, IL; Lundbeck, November 2013.
Sypazan™ [package insert] Warren, NJ; Aquestive Therapeutics. November 2018.