ALASKA MEDICAID
Prior Authorization Criteria

Sympazan™(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*

Criteria for Approval[1,2,3]:

1. Diagnosis of:
   a. Lennox-Gastaut Syndrome; **OR**
   b. Dravet Syndrome; **OR**
   c. Treatment-refractory epilepsy/seizures
2. Must be prescribed by or in consultation with a neurologist; **AND**
3. Current therapy with at least one other antiepileptic medication including documentation of current and prior therapies; **AND**
4. Recipient is 2 years of age or older; **AND**
5. Patient has tried and failed generic clobazam.

Length of Authorization:

- Coverage may be approved for up to 6 months.

Quantity Limit[1]**:**

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

Dosage Form/Strength

Films: 5mg, 10mg, 20 mg

References:

1. Sympazan™ [package insert] Warren, NJ; Aquestive Therapeutics. November 2018.
2. Knupp KG, Wirrell EC. Treatment Strategies for Dravet Syndrome. *CNS Drugs*. 2018;32(4):335-350
3. Clobazam. Lexi-Drugs. Lexicomp. Wolters Kluwer Health, Inc. Riverwoods, IL. Available at: http://online.lexi.com. Accessed December 28, 2022

*Prior authorization criteria for generic clobazam tablets and oral suspension to be retired as of 03/01/2023.

Sympazan™ criteria
Version 4
Last updated: 03/01/2023
Previous: 09/19/2014
Approved: 9/20/2019
Effective: 11/20/2019