CLOBAZAM-SYMPAZAN

Generic	Brand	HICL	GCN	Exception/Other
CLOBAZAM	SYMPAZAN		45264 45265 45266	

GUIDELINES FOR USE

1. Does the patient have a diagnosis of Lennox-Gastaut syndrome and meet **ALL** of the following criteria?
   - The requested medication will be used for adjunctive treatment of seizures associated with Lennox-Gastaut syndrome (i.e., in combination with lamotrigine or topiramate)
   - The patient is 2 years of age or older
   - Physician attestation that the patient is unable to take tablets or suspension
   - The patient has had a trial of or contraindication to generic/branded clobazam products (Onfi)

   If yes, **approve for 12 months by GPID for all of the following strengths with a quantity limit of #2 films per day:**
   - **Sympazan 5mg film (GPID 45264).**
   - **Sympazan 10mg film (GPID 45265).**
   - **Sympazan 20mg film (GPID 45266).**

   If no, do not approve.
   DENIAL TEXT: The guideline named **CLOBAZAM-SYMPAZAN** requires a diagnosis of Lennox-Gastaut Syndrome. The following criteria must also be met:
   - The requested medication will be used for adjunctive treatment of seizures associated with Lennox-Gastaut syndrome (i.e., in combination with lamotrigine or topiramate)
   - The patient is 2 years of age or older
   - Physician attestation that the patient is unable to take tablets or suspension
   - The patient has had a trial of or contraindication to generic/branded clobazam products (Onfi)

RATIONALE
For further information, please refer to the Prescribing Information and/or Drug Monograph for Sympazan.

REFERENCES

- Sympazan [Prescribing Information]. Warren, NJ. Aquestive Therapeutics; November 2018.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A   Created: 02/19
Commercial Effective: 04/01/19   Client Approval: 03/19   P&T Approval: 01/19

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