Clinical Policy: Stiripentol (Diacomit)
Reference Number: CP.PMN.184
Effective Date: 09.25.18
Last Review Date: 11.20
Line of Business: Commercial, HIM, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Stiripentol (Diacomit®) is an anticonvulsant.

FDA Approved Indication(s)
Diacomit is indicated for the treatment of seizures associated with Dravet syndrome in patients 2 years of age and older taking clobazam. There are no clinical data to support the use of Diacomit as monotherapy in Dravet syndrome.

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 Diacomit is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Dravet Syndrome (must meet all):
      1. Diagnosis of Dravet syndrome;
      2. Prescribed by or in consultation with a neurologist;
      3. Age ≥ 2 years;
      4. Will be used as adjunctive therapy (see Appendix B) with at least one other antiepileptic drug;
      5. Failure of ≥ 3 month trial of Epidiolex® at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
      6. Dose does not exceed 50 mg/kg (up to a maximum of 3,000 mg) per day.

   Approval duration:
   Medicaid/HIM – 12 months
   Commercial – Length of Benefit

   B. Other diagnoses/indications
      1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy
   A. Dravet Syndrome (must meet all):
CLINICAL POLICY
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1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Diacomit for Dravet syndrome and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. Diacomit will continue to be used as adjunctive therapy (see Appendix B) with at least one other antiepileptic drug;
4. If request is for a dose increase, new dose does not exceed 50 mg/kg (up to a maximum of 3,000 mg) per day.

Approval duration:
Medicaid/HIM – 12 months
Commercial – Length of Benefit

B. Other diagnoses/indications (must meet 1 or 2):
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, 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.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information
Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
EEG: electroencephalography
MRI: magnetic resonance imaging
NICE: National Institute for Health and Care Excellence

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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>clobazam (Onfi®, Sympazan®)</td>
<td>Initial: 0.2-0.3 mg/kg/day PO*</td>
<td>0.5-2 mg/kg/day</td>
</tr>
<tr>
<td>valproic acid (Depakene®, Depakote®, Stavzor®)</td>
<td>Initial: 10-15 mg/kg/day PO, given in 2-3 equally divided doses*</td>
<td>25-60 mg/kg/day</td>
</tr>
<tr>
<td>topiramate (Topamax®, Trokendi® XR, Qudexy® XR)</td>
<td>Initial: 0.5-2 mg/kg/day PO*</td>
<td>8-12 mg/kg/day</td>
</tr>
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</table>
Dravet syndrome, also known as severe myoclonic epilepsy of infancy (SMEI), is a severe form of epilepsy with an incidence of 1 in 15,700 to 1 in 40,900. Diagnosis is largely based on clinical presentation as magnetic resonance imaging (MRI) is usually normal and electroencephalography (EEG) findings are nonspecific.

Complete seizure control is typically not achievable, so the primary goal of therapy is to reduce seizure frequency. The following therapies are recommended for the management of Dravet syndrome by the United Kingdom National Institute for Health and Care Excellence (NICE; April 2018) and a North American Consensus Panel (January 2017):

- **NICE**
  - 1st line: Valproic acid or topiramate
  - 2nd line: Addition of clobazam or Diacomit
  - 3rd line: Refer to tertiary specialist

- **North American Consensus Panel**
  - 1st line: Valproic acid or clobazam (If first choice is not effective, then add the other)
  - 2nd line: Addition of Diacomit or topiramate
  - 3rd line: Addition of clonazepam, levetiracetam, zonisamide, ethosuximide, or phenobarbital

Diacomit increases plasma concentrations of clobazam through inhibition of CYP3A4 and 2C19.

FDA-approved in August 2018, Diacomit had long prior been used in clinical practice in Canada, Japan, and European countries as well as off-label in the United States through a compassionate-use program.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dravet syndrome</td>
<td>50 mg/kg/day PO in 2-3 divided doses</td>
<td>3,000 mg/day</td>
</tr>
</tbody>
</table>
• Powder for oral suspension: 250 mg, 500 mg

VII. References

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tbody>
<tr>
<td>Policy created</td>
<td>09.25.18</td>
<td>11.18</td>
</tr>
<tr>
<td>4Q 2019 annual review: added requirement that Diacomit continue to be used as adjunctive therapy for reauthorization; references reviewed and updated.</td>
<td>08.01.19</td>
<td>11.19</td>
</tr>
<tr>
<td>Added HIM line of business per SDC and prior clinical guidance.</td>
<td>10.07.19</td>
<td></td>
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<tr>
<td>4Q 2020 annual review: no significant changes; references reviewed and updated.</td>
<td>08.04.20</td>
<td>11.20</td>
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<tr>
<td>Per November SDC and prior clinical guidance, added redirect to Epidiolex</td>
<td>11.16.20</td>
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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.

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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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