

## Clinical Policy: Stiripentol (Diacomit)

Reference Number: CP.PMN.184

Effective Date: 09.25.18

Last Review Date: 11.25

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Stiripentol (Diacomit<sup>®</sup>) is an anticonvulsant.

### FDA Approved Indication(s)

Diacomit is indicated for the treatment of seizures associated with Dravet syndrome in patients taking clobazam who are 6 months of age and older and weighing 7 kg or more. 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<sup>®</sup> 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  $\geq$  6 months;
  4. Member weighs  $\geq$  7 kg;
  5. Will be used as adjunctive therapy (*see Appendix B*) with at least one other antiepileptic drug;
  6. Failure of  $\geq$  3 month trial of Epidiolex<sup>®</sup> at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;\*
- \*For Illinois HIM requests, the step therapy requirement above does not apply as of 1/1/2026 per IL HB 5395.*
7. Dose does not exceed 50 mg/kg (up to a maximum of 3,000 mg) per day.

##### Approval duration:

**Medicaid/HIM** – 12 months

**Commercial** – 12 months or duration of request, whichever is less

##### B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business:

- CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## II. Continued Therapy

### A. Dravet Syndrome (must meet all):

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** – 12 months or duration of request, whichever is less

### B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 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.PA.154 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.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
clobazam (Onfi <sup>®</sup> , Sympazan <sup>®</sup> )	Initial: 0.2-0.3 mg/kg/day PO*	0.5-2 mg/kg/day
valproic acid (Depakene <sup>®</sup> , Depakote <sup>®</sup> , Stavzor <sup>®</sup> )	Initial: 10-15 mg/kg/day PO, given in 2-3 equally divided doses*	25-60 mg/kg/day
topiramate (Topamax <sup>®</sup> , Trokendi <sup>®</sup> XR, Qudexy <sup>®</sup> XR)	Initial: 0.5-2 mg/kg/day PO*	8-12 mg/kg/day
levetiracetam (Spritam <sup>®</sup> , Keppra <sup>®</sup> )	Initial: 10-20 mg/kg/day PO, divided in 2-3 doses*	60-80 mg/kg/day
Other antiepileptic drugs: clonazepam (Klonopin <sup>®</sup> ), zonisamide (Zonegran <sup>®</sup> ), ethosuximide (Zarontin <sup>®</sup> ), phenobarbital	PO; off-label dosing information not available	Off-label dosing information not available
Epidiolex <sup>®</sup> (cannabidiol)	Initial: 2.5 mg/kg PO BID Maintenance: 5 mg/kg PO BID	20 mg/kg/day

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*\*Off-label*

*Appendix C: Contraindications/Boxed Warnings*

None reported

*Appendix D: General Information*

- 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	North American Consensus Panel
1 <sup>st</sup> line	Valproic acid or topiramate	Valproic acid or clobazam <i>If first choice is not effective, then add the other</i>
2 <sup>nd</sup> line	Addition of clobazam or Diacomit	Addition of Diacomit or topiramate
3 <sup>rd</sup> line	Refer to tertiary specialist	Addition of clonazepam, levetiracetam, zonisamide, ethosuximide, or phenobarbital

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

#### V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Dravet syndrome	Age ≥ 6 months and weighing 7 kg to < 10 kg: 25 mg/kg twice daily Age ≥ 1 year and weighing ≥ 10 kg: 25 mg/kg twice daily or 16.67 mg/kg three times daily	50 mg/kg/day (not to exceed 3,000 mg/day)

#### VI. Product Availability

- Capsules: 250 mg, 500 mg
- Powder for oral suspension: 250 mg, 500 mg

#### VII. References

1. Diacomit Prescribing Information. Beauvais, France: Biocodex; July 2022. Available at: <https://www.diacomit.com/prescribing-information/>. Accessed July 15, 2025.
2. Wirrell EC, Laux L, Jette N, et al. Optimizing the diagnosis and management of Dravet syndrome: recommendations from a North American consensus panel. *Pediatr Neurol.* 2017; 68:18-34.
3. National Institute for Health and Care Excellence (NICE). Epilepsies: diagnosis and management. Available at: <https://www.nice.org.uk/guidance/CG137/chapter/Appendix-E-Pharmacological-treatment>. Accessed August 1, 2019.
4. Wirrell EC, Hood V, Knupp KG et al. International consensus on diagnosis and management of Dravet syndrome. *Epilepsia.* 2022;63:1761-77. DOI: 10.1111/epi.17274.
5. Strzelczyk A, Schubert-Bast S. A practical guide to the treatment of Dravet syndrome with anti-seizure medication. *CNS Drugs.* 2022;36:217–237. <https://doi.org/10.1007/s40263-022-00898-1>.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2021 annual review: no significant changes; revised HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	08.22.21	11.21
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less	01.20.22	05.22
4Q 2022 annual review: no significant changes; RT4: updated the policy to reflect the new indication expansion to patients ≥ 6	08.25.22	11.22

Reviews, Revisions, and Approvals	Date	P&T Approval Date
months of age and weighing $\geq 7$ kg; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section.		
4Q 2023 annual review: no significant changes; references reviewed and updated.	08.16.23	11.23
4Q 2024 annual review: no significant changes; references reviewed and updated.	08.07.24	11.24
4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.	08.26.25	11.25

**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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible

for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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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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