Drug Coverage Policy

Effective Date 11/15/2025
Coverage Policy Number IP0048
Policy Title ..... Rufinamide

Antiseizure Medications – Rufinamide

- **Banzel® (rufinamide tablets and oral suspension – Eisai, generic)**

INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

OVERVIEW

Rufinamide is indicated for adjunctive treatment of **seizures associated with Lennox-Gastaut syndrome** (LGS) in patients ≥ 1 year of age.[1]

Although rufinamide is only FDA-approved for use in LGS, clinical trial data indicate the drug may also be beneficial as adjunctive treatment of refractory focal epilepsy.[2] A review of six clinical trials found that rufinamide, when used as an add-on treatment, was effective in reducing seizure frequency in patients with drug-resistant focal epilepsy.

Disease Overview
LGS is a severe epileptic and developmental encephalopathy associated with a high rate of morbidity and mortality.[3,4] LGS most often begins between 3 years and 5 years of age and comprises approximately 3% to 4% of childhood epilepsies.[3-6] Affected children experience several different types of seizures, most commonly atonic seizures (sudden loss of muscle tone and limpness, also called drop seizures) and tonic seizures (increased muscle tone and muscle stiffness).[3,6] The three main forms of treatment of LGS are antiseizure medications (ASMs), dietary therapy (typically the ketogenic diet), and device/surgery (e.g., vagus nerve stimulation, corpus callosotomy).[6] None of the therapies are effective in all cases of LGS and the disorder has proven particularly resistant to most therapeutic options. The choice of treatment should take into consideration the patient's age and other associated conditions.

Guidelines/Recommendations
Lennox-Gastaut syndrome: Currently, the FDA-approved drugs for this condition are Epidiolex® (cannabidiol oral solution), clobazam, clonazepam, felbamate, Fintepla® (fenfluramine oral solution), lamotrigine, rufinamide, and topiramate.[7] Despite the lack of level I or level II evidence, valproic acid remains a mainstay in treatment.[5,6,8] If valproic acid does not provide adequate seizure control, which is almost always the case, lamotrigine should be added as the first adjunctive therapy.[4] If the combination regimen of valproic acid and lamotrigine does not provide adequate control, then rufinamide should be initiated and either valproic acid or lamotrigine should be discontinued. If seizure control is still not achieved, the next adjunctive therapies to consider are topiramate, clobazam, and felbamate. There is limited evidence for the use of levetiracetam, zonisamide, and Fycompa® (perampanel tablets and oral suspension). Where possible, no more than two ASMs should be used concomitantly; use of multiple ASMs increase the risk of side effects and/or drug-drug interactions.

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POLICY STATEMENT
Prior Authorization is required for benefit coverage of rufinamide. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with rufinamide as well as the monitoring required for adverse events and long-term efficacy, initial approval requires rufinamide to be prescribed by or in consultation with a physician who specializes in the condition being treated.

Rufinamide products are considered medically necessary when ONE of the following criteria are met:

FDA-Approved Indication

1. **Lennox-Gastaut Syndrome.** Approve for 1 year if the patient meets ONE of the following (A or B):
    A. Initial Therapy. Approve if the patient meets ALL of the following (i, ii, iii, and iv):
        i. Patient is ≥ 1 year of age; AND
        ii. Patient has tried and/or is concomitantly receiving at least two other antiseizure medications; AND
        Note: Examples of antiseizure medications include valproic acid, gabapentin, phenytoin, carbamazepine, oxcarbazepine, lacosamide, levetiracetam,

zonisamide, Fycompa (perampanel tablet or oral suspension), vigabatrin, lamotrigine, topiramate, clobazam, Diacomit (stiripentol capsules or oral suspension), Epidiolex (cannabidiol oral solution), and felbamate.

iii. The medication is prescribed by, or in consultation with, neurologist; AND
iv. Preferred product criteria is met for the product(s) as listed in the below table(s):

B. Patient is Currently Receiving rufinamide. Approve if the patient is responding to therapy (e.g.), reduced seizure severity, frequency, and/or duration) as determined by the prescriber.

Other Uses with Supportive Evidence

2. **Treatment-Refractory Seizures/Epilepsy.** Approve for 1 year if the patient meets ONE of the following (A or B):
   A. Initial Therapy. Approve if the patient meets ALL of the following (i, ii, iii and iv):
      i. Patient is ≥1 year of age; AND
      ii. Patient has tried and/or is concomitantly receiving at least two other antiseizure medications; AND
      Note: Examples of antiseizure medications include valproic acid, gabapentin, phenytoin, carbamazepine, oxcarbazepine, lacosamide, levetiracetam, zonisamide, Fycompa (perampanel tablet or oral suspension), vigabatrin, lamotrigine, topiramate, clobazam, Diacomit (stiripentol capsules or oral suspension), Epidiolex (cannabidiol oral solution), and felbamate.
      iii. The medication is prescribed by, or in consultation with, neurologist; AND
      iv. Preferred product criteria is met for the product(s) as listed in the below table(s):
   B. Patient is Currently Receiving rufinamide. Approve if the patient is responding to therapy (e.g., reduced seizure severity, frequency, and/or duration) as determined by the prescriber.

Employer Plans:

Non-Covered Product	Criteria
Banzel (rufinamide oral suspension)	The patient has tried the bioequivalent generic product AND cannot take due to a formulation difference in the inactive ingredient(s) [for example, difference in dyes, fillers, preservatives] between the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.
Banzel (rufinamide tablets)	The patient has tried the bioequivalent generic product AND cannot take due to a formulation difference in the inactive ingredient(s) [for example, difference in dyes, fillers, preservatives] between the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.

Individual and Family Plans:

Non-Covered Product	Criteria
Banzel (rufinamide oral suspension)	The patient has tried the bioequivalent generic product AND cannot take due to a formulation difference in the inactive ingredient(s) [for example, difference in dyes, fillers, preservatives] between the brand and the bioequivalent

Non-Covered Product	Criteria
	generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.
Banzel (rufinamide tablets)	The patient has tried the bioequivalent generic product AND cannot take due to a formulation difference in the inactive ingredient(s) [for example, difference in dyes, fillers, preservatives] between the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.

Conditions Not Covered

Rufinamide for any other use is considered not medically necessary. Criteria will be updated as newly published data are available.

References

1. Banzel® tablets and oral suspension [prescribing information]. Woodcliff Lake, NJ: Eisai; November 2019.
2. Brigo F, Jones K, Eltze C, et al. Anti-seizure medications for Lennox-Gastaut syndrome. *Cochrane Database Syst Rev*. 2021;4(4):CD003277.
3. Sirven JI, Shafer PO. Epilepsy Foundation – Lennox-Gastaut Syndrome. Updated February 2020. Available at: https://www.epilepsy.com/learn/types-epilepsy-syndromes/lennox-gastaut-syndrome-lgs/. Accessed on August 26, 2025.
4. Cross JH, Auvin S, Falip M, et al. Expert opinion on the management of Lennox-Gastaut syndrome: treatment algorithms and practical considerations. *Front Neurol*. 2017;8:505.
5. Ostendorf AP, Ng YT. Treatment-resistant Lennox-Gastaut syndrome: therapeutic trends, challenges, and future directions. *Neuropsych Dis Treatment*. 2017;13:1131-1140.
6. Wheless JW. National Organization for Rare Diseases (NORD) – Lennox-Gastaut syndrome. Updated May 20, 2024. Available at: https://rarediseases.org/rare-diseases/lennox-gastaut-syndrome/. Accessed on August 26, 2025.
7. Lennox-Gastaut Syndrome Foundation – Lennox-Gastaut Syndrome. Updated September 26, 2024. Available at: https://www.lgsfoundation.org/about-lgs-2/how-is-lgs-treated/. Accessed on August 26, 2025.
8. Cherian KA. Lennox-Gastaut syndrome treatment & management. Updated September 10, 2024. Available at: https://emedicine.medscape.com/article/1176735-treatment/. Accessed on August 26, 2025.

Revision Details

Type of Revision	Summary of Changes	Date
Selected Revision	No criteria changes.	12/15/2024
Annual Revision	**Policy Title:** **Updated** from "Rufinamide" to "Antiseizure Medications-Rufinamide". **Added** Preferred Product Criteria for Individual and Family Plans.	11/15/2025

	Throughout the criteria, reference to antiepileptic drugs was changed to antiseizure medications.	

The policy effective date is in force until updated or retired.