

## PRIOR AUTHORIZATION POLICY

**POLICY:** Antiseizure Medications – Valtoco Prior Authorization Policy

- Valtoco® (diazepam nasal spray – Neurelis)

**REVIEW DATE:** 02/19/2025

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### OVERVIEW

Valtoco, a benzodiazepine, is indicated for the acute treatment of **intermittent, stereotypic episodes of frequent seizure activity** (i.e., seizure clusters, acute repetitive seizures) that are distinct from a patient's usual seizure pattern in patients with epilepsy  $\geq 6$  years of age.<sup>1</sup>

Valtoco is for acute treatment only. Do not use more than two doses of Valtoco to treat a single episode.<sup>1</sup> It is recommended that Valtoco be used to treat no more than one episode every 5 days and no more than five episodes per month.

### Disease Overview

Patients with epilepsy can experience acute repetitive seizures or seizure clusters.<sup>2</sup> Patients with severe and/or poorly controlled epilepsy are more likely to experience seizure clusters. Seizure clusters can result in increased emergency room visits or hospitalization, and they can disrupt the daily life, studies, and work of patients and caregivers. They are particularly concerning because of their association with status epilepticus, a potentially life-threatening condition. Benzodiazepine rescue medication is the primary acute therapy for management of seizure clusters, helping to abort clusters and reduce emergency department visits.

### POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Valtoco. All approvals are provided for the duration noted below.

**Automation:** None.

### RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Valtoco is recommended in those who meet the following criteria:

#### FDA-Approved Indication

1. **Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures).** Approve for 1 year if the patient meets BOTH of the following (A and B):
    - A) Patient is currently receiving maintenance antiseizure medication(s); AND
    - B) The medication is prescribed by or in consultation with a neurologist.
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### CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Valtoco is not recommended in the following situations:

1. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

### REFERENCES

1. Valtoco<sup>®</sup> nasal spray [prescribing information]. San Diego, CA: Neurelis; January 2023.
2. Jafarpour S, Hirsch LJ, Gaínza-Lein M, et al. Seizure cluster: Definition, prevalence, consequences, and management. *Seizure*. 2019;68:9-15.

### HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	The policy name was changed from Antiepileptics – Valtoco Prior Authorization Policy to Antiseizure Medications – Valtoco Prior Authorization Policy. <b>Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures):</b> The term antiepileptic medications was changed to antiseizure medications.	02/15/2023
Annual Revision	No criteria changes.	02/07/2024
Annual Revision	No criteria changes.	02/19/2025

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