

Clinical Policy: Vigabatrin (Sabril, Vigafyde)

Reference Number: CP.PHAR.169

Effective Date: 02.01.16

Last Review Date: 08.26

Line of Business: Commercial, HIM/ICHRA, Medicaid

[Revision Log](#)

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

Description

Vigabatrin (Sabril[®], Vigafyde[™]) is an anticonvulsant.

FDA Approved Indication(s)

Sabril is indicated:

- For the treatment of refractory complex partial seizures as adjunctive therapy in patients ≥ 2 years of age who have responded inadequately to several alternative treatments and for whom the potential benefits outweigh the risk of vision loss; Sabril is not indicated as a first line agent for complex partial seizures.
- For the treatment of infantile spasms as monotherapy in infants 1 month to 2 years of age for whom the potential benefits outweigh the potential risk of vision loss.

Vigafyde is indicated as monotherapy for the treatment of infantile spasms in pediatric patients 1 month to 2 years of age for whom the potential benefits outweigh the potential risk of vision loss.

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 vigabatrin, Sabril, and Vigafyde are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Infantile Spasms (must meet all):**

1. Diagnosis of infantile spasms;
2. Prescribed by or in consultation with a neurologist;
3. Age between 1 month to 2 years;
4. For brand Sabril requests, member must use generic vigabatrin, unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 150 mg/kg per day.

Approval duration: 12 months or up to 2 years of age, whichever is less

B. Refractory Complex Partial Seizures (must meet all):

1. Diagnosis of refractory complex partial seizures;
2. Request is for Sabril;
3. Prescribed by or in consultation with a neurologist;
4. Age ≥ 2 years;

5. Sabril will be used as adjunctive therapy;
6. Member meets one of the following (a or b):
 - a. Request is for the treatment of a member in a State with limitations on step therapy in certain settings (*see Appendix D*);
 - b. Failure of three preferred alternative anticonvulsant drugs (*see Appendix B for examples*);
7. For brand Sabril requests, member must use generic vigabatrin, unless contraindicated or clinically significant adverse effects are experienced;
8. Dose does not exceed any of the following (a or b):
 - a. Pediatric members aged 2 to 16 years (*members > 60 kg should be dosed as adults*) (i and ii):
 - i. 2,000 mg per day;
 - ii. 4 tablets or packets per day;
 - b. Adults aged ≥ 17 years (i and ii):
 - i. 3,000 mg per day;
 - ii. 6 tablets or packets per day.

Approval duration: 12 months

C. 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/ICHRA) 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/ICHRA and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA 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/ICHRA and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Infantile Spasms (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Sabril or Vigafyde for infantile spasms and has received this medication for at least 30 days;
2. Age between 1 month to 2 years;
3. Member is responding positively to therapy;
4. For brand Sabril requests, member must use generic vigabatrin, unless contraindicated or clinically significant adverse effects are experienced;
5. If request is for a dose increase, new dose does not exceed 150 mg/kg per day.

Approval duration: 12 months or up to 2 years of age, whichever is less

B. Refractory Complex Partial Seizures (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Sabril for refractory complex partial seizures and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. For brand Sabril requests, member must use generic vigabatrin, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, new dose does not exceed any of the following (a or b):
 - a. Pediatric members aged 2 to 16 years (*members > 60 kg should be dosed as adults*) (i and ii):
 - i. 2,000 mg per day;
 - ii. 4 tablets or packets per day;
 - b. Adults aged ≥ 17 years (i and ii):
 - i. 3,000 mg per day;
 - ii. 6 tablets or packets per day.

Approval duration: 12 months

C. 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/ICHRA) 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/ICHRA and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) 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/ICHRA 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/ICHRA 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/ICHRA 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

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.

Drug Class	Examples	Dose Limit/ Maximum Dose
Anticonvulsants for partial seizures	carbamazepine (Tegretol [®]), felbamate (Felbatol [®]), gabapentin (Neurontin [®]), lamotrigine (Lamictal [®]), levetiracetam (Keppra [®]), oxcarbazepine (Trileptal [®]), phenytoin (Dilantin [®]), tiagabine (Gabitril [®]), topiramate (Topamax [®]), valproic acid (Depakene [®]), divalproex sodium (Depakote [®]), zonisamide (Zonegran [®])	Varies according to the agent used

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications / Boxed Warnings

- Contraindication(s): none reported
- Boxed warnings: permanent vision loss

Appendix D: States with Limitations against Redirections in Certain Settings

State	Step Therapy Prohibited?	Notes
NV	No	<i>*Applies to Medicaid requests only*</i> Failure of ONE alternative anticonvulsant drug (<i>see Appendix B for examples</i>), unless all are contraindicated or clinically significant adverse effects are experienced.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Infantile spasms	50 mg/kg/day (25 mg/kg PO BID); increase total daily dose every 3 days in increments of 25 mg/kg/day to 50 mg/kg/day	150 mg/kg/day (75 mg/kg twice daily)
Complex partial seizures	Adults (≥ 17 years): 1,000 mg/day (500 mg PO BID); increase total daily dose weekly in 500 mg/day increments to 3,000 mg/day Pediatrics (2-16 years): • Weight 10-15 kg: 175 mg PO BID to 525 mg PO BID • Weight > 15 kg to 20 kg: 225 mg PO BID to 650 mg PO BID	Adults: 3,000 mg/day (1,500 mg twice daily) Pediatrics: 2,000 mg/day (1,000 mg twice daily)

Indication	Dosing Regimen	Maximum Dose
	- Weight > 20 kg to 25 kg: 250 mg PO BID to 750 mg PO BID - Weight > 25 kg to 60 kg: 250 mg PO BID to 1,000 mg PO BID - Patients weighing > 60 kg should be dosed according to adult recommendations.	

VI. Product Availability

Drug Name	Availability
Vigabatrin (Sabril)	Tablet: 500 mg Powder for oral solution: 500 mg per packet
Vigabatrin (Vigafyde)	Oral solution: 100 mg/mL

VII. References

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2. Vigafyde Prescribing Information. Parsippany, NJ: Pyros Pharmaceuticals, Inc. September 2025. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/217684s002s004lbl.pdf. Accessed April 7, 2026.
3. Hancock EC, Osborne JP, Edwards SW. Treatment of infantile spasms. Cochrane Epilepsy Group – Cochrane Database of Syst Rev. June 5, 2013; 6: CD001770. doi: 10.1002/14651858.CD001770.pub3.
4. Pellock JM, Hrachovy R, Shinnar S, et al. Infantile spasms: A U.S. consensus report. *Epilepsia*. October 2010; 51(10): 2175-89. doi: 10.1111/j.1528-1167.2010.02657.x.
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7. Kanner AM, et al. Practice guideline update summary: efficacy and tolerability of the new antiepileptic drugs I: treatment of new-onset epilepsy. *Neurology* 2018;91:74-81.
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Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2022 annual review: no significant changes; references reviewed and updated.	05.12.22	08.22
Template changes applied to other diagnoses/indications.	09.30.22	
3Q 2023 annual review: no significant changes; references reviewed and updated.	05.18.23	08.23

Reviews, Revisions, and Approvals	Date	P&T Approval Date
For refractory complex partial seizures, added redirection bypass for members in a State with limitations on step therapy in certain settings along with Appendix D, which includes Nevada with requirements for single drug redirection for Medicaid requests.	08.31.23	
3Q 2024 annual review: no significant changes; references reviewed and updated. RT4: added newly FDA-approved Vigafyde oral solution to the criteria.	06.28.24	08.24
3Q 2025 annual review: no significant changes; added a generic redirection for brand Sabril; references reviewed and updated.	06.06.25	08.25
3Q 2026 annual review: no significant changes; updated the Initial Approval duration for infantile spasms and refractory complex partial seizures from 3 months or 6 months, respectively, to 12 months (placing an upper age limit of 2 years for infantile spasms per the labeled indication and in alignment with the existing Continued Therapy approval duration); added Commercial line of business since PA is required on Tier 3 and Tier 4 Commercial formularies; added ICHRA line of business; references reviewed and updated.	04.07.26	08.26

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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