Clinical Policy: Respiratory Agents: Beta-Adrenergic Agonists – Inhaled, Long Acting

Reference Number: OH.PHAR.PPA.82
Effective Date: 01/01/2020
Last Review Date: 01/2022
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description:

RESPIRATORY AGENTS: BETA-ADRENERGIC, LONG-ACTING (LABA)

NO PA REQUIRED " PREFERRED"	PA REQUIRED "NON-PREFERRED"
SEREVENT DISKUS® (salmeterol) STRIVERDI RESPIMAT® (olodaterol)	BROVANA™ (arformoterol)[BvG] PERFOROMIST® (formoterol)[BvG]

BvG = Brand Preferred Over the Generic

RESPIRATORY AGENTS: BETA-ADRENERGIC-STEROID COMBINATIONS (LABA/ICS)

NO PA REQUIRED " PREFERRED"	PA REQUIRED "NON-PREFERRED"
ADVAIR® DISKUS (salmeterol/fluticasone)[BvG] ADVAIR® HFA (salmeterol/fluticasone) DULERA® (formoterol/mometasone) SYMBICORT® (formoterol/budesonide)[BvG]	AIRDUO™ DIGIHALER® (fluticasone/salmeterol) AIRDUO™ RESPICLICK® (fluticasone/salmeterol) BREO® ELLIPTA (fluticasone/vilanterol) FLUTICASONE/SALMETEROL (generic of Advair Diskus®) WIXELA™ Inhub™ (salmeterol/fluticasone)

BvG = Brand Preferred Over the Generic

RESPIRATORY AGENTS: BETA-ADRENERGIC-MUSCARINIC COMBINATIONS (LABA/LAMA)

NO PA REQUIRED " PREFERRED"	PA REQUIRED "NON-PREFERRED"
ANORO™ ELLIPTA (umeclidinium/vilanterol) STIOLTO RESPIMAT™ (tiotropium/olodaterol)	BEVESPI AEROSPHERE™ (glycopyrrolate/ formoterol) DUAKLIR PRESSAIR (aclidinium bromide/formoterol fumarate)

FDA Approved Indication(s)

Beta-Adrenergic Agonists, Long-Acting medications are indicated for the treatment of:

- asthma
- bronchospasm prophylaxis
- chronic bronchitis
- chronic obstructive pulmonary disease (COPD)
- emphysema
- exercise-induced bronchospasm prophylaxis

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 Buckeye Health Plan, an affiliate of Centene Corporation®, that Brovana, Perforomist, AirDuo Digihaler, AirDuo RespiClick, Breo Ellipta, Fluticasone/Salmeterol (generic of Advair Diskus), Wixela Inhub, Bevespi Aerosphere, and Duaklir Pressair are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. For Bevespi Aerosphere, Brovana, Duaklir Pressair, and Perforomist (must meet all)**:**
1. Diagnosis of chronic obstructive pulmonary disease (COPD);
2. Age ≥ 18 years;
3. Documentation that there has been a therapeutic failure to no less than a 14-day trial of at least one medication not requiring prior approval UNLESS there is a reason the member cannot be changed to a preferred medication. Acceptable reasons include:
   - Allergies to all medications not requiring prior approval.
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
   - History of unacceptable/toxic side effects to medications not requiring prior approval.

Approval duration: 12 months.

B. For Fluticasone/Salmeterol (generic of Advair Diskus) and Wixela Inhub (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Diagnosis of asthma AND age ≥ 4 years;
   b. Diagnosis of COPD AND age ≥ 18 years;
2. Documentation that there has been a therapeutic failure to no less than a 14-day trial of at least one medication not requiring prior approval UNLESS there is a reason the member cannot be changed to a preferred medication. Acceptable reasons include:
   - Allergies to all medications not requiring prior approval.
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
   - History of unacceptable/toxic side effects to medications not requiring prior approval.

NOTE: Brand name Advair Diskus is preferred with no PA required.

Approval duration: 12 months.

C. For AirDuo Digihaler and AirDuo RespiClick (must meet all)**:**
1. Diagnosis of asthma;
2. Age ≥ 12 years;
3. Documentation that there has been a therapeutic failure to no less than a 14-day trial of at least one medication not requiring prior approval UNLESS there is a reason the member cannot be changed to a preferred medication. Acceptable reasons include:

- Allergies to all medications not requiring prior approval.
- Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
- History of unacceptable/toxic side effects to medications not requiring prior approval.

Approval duration: 12 months.

D. For Breo Ellipta (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Diagnosis of asthma AND age ≥ 18 years;
   b. Diagnosis of COPD AND age ≥ 18 years;
2. Documentation that there has been a therapeutic failure to no less than a 14-day trial of at least one medication not requiring prior approval UNLESS there is a reason the member cannot be changed to a preferred medication. Acceptable reasons include:
   - Allergies to all medications not requiring prior approval.
   - Contraindication to or drug-to-drug interaction with medications not requiring prior approval.
   - History of unacceptable/toxic side effects to medications not requiring prior approval.

Approval duration: 12 months.

E. Other diagnoses/indications:

1. There are no pharmacy and therapeutic committee approved off-label use criteria for the diagnosis;
2. Use is supported by one of the following (a, b, or c):
   a. The National Comprehensive Cancer Network (NCCN) Drug Information and Biologics Compendium level of evidence 1 or 2A;
   b. Evidence from at least two high-quality, published studies in reputable peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (i – iv):
      i. Adequate representation of the member's clinical characteristics, age, and diagnosis;
      ii. Adequate representation of the prescribed drug regimen;
      iii. Clinically meaningful outcomes as a result of the drug therapy in question;
      iv. Appropriate experimental design and method to address research questions;
   c. Micromedex DrugDex® with strength of recommendation Class I, IIa, or IIb;
3. Prescribed by or in consultation with an appropriate specialist for the diagnosis;
4. Failure of an adequate trial of at least two FDA-approved drugs for the indication and/or drugs that are considered the standard of care, when such agents exist for the same indication at maximum indicated doses, unless no such drugs exist, at maximum indicated doses, unless contraindicated or clinically significant adverse effect are experienced;
5. Dosing regimen and duration are within dosing guidelines recommended by clinical practice guidelines and/or medical literature.

Approval duration: 12 months.

II. Diagnoses/Indications for which coverage is NOT authorized:

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.PMN.53 for Medicaid or evidence of coverage documents.

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

COPD: Chronic Obstructive Pulmonary Disease
FDA: Food and Drug Administration
ICS: Inhaled Corticosteroid
LABA: Long-Acting Beta Agonist
LAMA: Long-Acting Muscarinic Antagonist
PA: Prior Authorization

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 Name	Dosing Regimen	Dose Limit/ Maximum Dose
Serevent Diskus® (salmeterol)	1 inhalation (50 mcg) twice daily	100 mcg/day
Striverdi® Respimat® (olodaterol)	2 actuations inhaled once daily	5 mcg (2 actuations) per 24 hours
Advair Diskus® (fluticasone/salmeterol)	Asthma: 1 actuation inhaled twice daily of either 100 mcg/50 mcg, 250 mcg/50 mcg, or 500 mcg/50 mcg COPD: 1 actuation of 250 mcg/50 mcg inhaled twice daily	1 inhalation of 500 mcg/50 mcg twice daily for asthma; 1 inhalation of 250 mcg/50 mcg twice daily for COPD
Advair® HFA (fluticasone/salmeterol)	2 inhalations inhaled twice daily	2 inhalations of 230 mcg/21 mcg twice daily
Dulera® (formoterol/mometasone)	2 inhalations inhaled twice daily	800 mcg of mometasone and 20 mcg of formoterol/day
Symbicort® (formoterol/budesonide)	2 actuations inhaled twice daily	640 mcg of budesonide and 18 mcg of formoterol via oral inhalation/day
Anoro™ Ellipta (umeclidinium/vilanterol)	1 actuation (62.5 mcg of umeclidinium and 25 mcg of vilanterol per actuation) inhaled once daily	62.5 mcg/day of umeclidinium and 25 mcg/day of vilanterol via oral inhalation
Stiolto® Respimat® (tiotropium/olodaterol)	2 actuations inhaled once daily	5 mcg of tiotropium and 5 mcg of olodaterol per day

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):
  - Acute Bronchospasm
  - Milk Protein Hypersensitivity
  - Monotherapy treatment of asthma
  - Status Asthmaticus

IV. Dosage and Administration

- Varies by drug product. See FDA approved dosing and administration AND Appendix B.

V. Product Availability

Drug Name	Availability
Advair HFA	Inhalation aerosol: 55 mcg-14 mcg/actuation, 113 mcg-14 mcg/actuation, 230 mcg-21 mcg/actuation
AirDuo Digihaler	Inhalation powder: 55 mcg-14 mcg/actuation, 113 mcg-14 mcg/actuation, 232 mcg-14 mcg/actuation
AirDuo RespiClick	Inhalation powder: 55 mcg-14 mcg/actuation, 113 mcg-14 mcg/actuation, 232 mcg-14 mcg/actuation
Anoro Ellipta	Inhalation powder: 62.5 mcg-25 mcg/actuation
Arcapta Neohaler	Inhalation powder: 75 mcg
Bevespi Aerosphere	Inhalation aerosol: 9 mcg-4.8 mcg/actuation
Breo Ellipta	Inhalation powder: 100 mcg-25 mcg/actuation, 200 mcg-25 mcg/actuation
Brovana	Inhalation solution: 15 mcg/2 mL
Duaklir Pressair	Inhalation powder: 400 mcg-12 mcg/actuation
Dulera	Inhalation aerosol: 100 mcg-5 mcg/actuation, 200 mcg-5 mcg/actuation
Perforomist	Inhalation solution: 20 mcg/2 mL
Salmeterol/Fluticasone (generic of Advair Diskus)	Inhalation powder: 100 mcg-50 mcg/actuation, 250 mcg-50 mcg/actuation, 500 mcg-50 mcg/actuation
Serevent Diskus	Inhalation powder: 50 mcg/actuation
Stiolto Respimat	Inhalation spray: 2.5 mcg-2.5 mcg/actuation
Striverdi Respimat	Inhalation solution: 2.5 mcg/actuation
Symbicort	Inhalation aerosol: 80 mcg-4.5 mcg/actuation, 160 mcg-4.5 mcg/actuation
Utibron Neohaler	Inhalation powder: 27.5 mcg-15.6 mcg
Wixela Inhub	Inhalation powder: 100 mcg-50 mcg/actuation, 250 mcg-50 mcg/actuation, 500 mcg-50 mcg/actuation

VI. References

- Salmeterol. Clinical Pharmacology. Elsevier. Tampa, FL. Available at https://www.clinicalpharmacology-ip.com. Accessed November 11, 2019.
- Salmeterol/Fluticasone. Clinical Pharmacology. Elsevier. Tampa, FL. Available at https://www.clinicalpharmacology-ip.com. Accessed November 11, 2019.

- Formoterol/Glycopyrrolate. Clinical Pharmacology. Elsevier. Tampa, FL. Available at https://www.clinicalpharmacology-ip.com. Accessed November 11, 2019.
- Indacaterol/Glycopyrrolate. Clinical Pharmacology. Elsevier. Tampa, FL. Available at https://www.clinicalpharmacology-ip.com. Accessed November 11, 2019.
- Vilanterol/Fluticasone. Clinical Pharmacology. Elsevier. Tampa, FL. Available at https://www.clinicalpharmacology-ip.com. Accessed November 11, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created.	10.19	N/A
Policy updated.	11.20	N/A
Annual review. Removed Utibron Neohaler from list of preferred medications. Removed Arcapta Neohaler from list of non-preferred medications. Added AirDuo Digihaler to the list of non-preferred medications.	10.21	N/A
ODM Q4 P&T update. Added Striverdi Respimat, brand Advair Diskus, Advair HFA, Anoro Ellipta, and Stiolto Respimat to list of preferred medications. Added Bevespi Aerosphere and Fluticasone/Salmeterol (generic of Advair Diskus) to list of non-preferred medications.	01.22	N/A

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.