Clinical Policy: Endocrine Agents: Diabetes – Hypoglycemia Treatments

Reference Number: OH.PHAR.PPA.97
Effective Date: 01/01/2021 Revision Log
Last Review Date: 12/2020
Line of Business: Medicaid

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

Description

Endocrine Agents: Diabetes – Hypoglycemia Treatments

NO PA REQUIRED "PREFERRED"	STEP THERAPY REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
GLUCAGEN vial (glucagon, human recombinant) GLUCAGON EMERGENCY KIT (glucagon, human recombinant)	BAQSIMI nasal spray (glucagon)	GVOKE HYPOPEN 1-PACK (glucagon) GVOKE PFS (glucagon)

Quantity limit of 2 per month

FDA approved indication(s)

Antihypoglycemic agents are indicated for:

- Treatment of severe hypoglycemia in patients with diabetes mellitus, neonates (intermittent intramuscular, intravenous, or subcutaneous dosage only), and psychotic patients receiving insulin shock therapy in adults (intramuscular or intravenous dosage only)
- For use as a diagnostic aide in radiographic examination and magnetic resonance imaging (MRI) of the GI tract in adults (intramuscular or intravenous dosage only)

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 Hypoglycemia Treatments are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

1. Prescribed indication is FDA-approved or supported by standard pharmacopeias;
2. Member must meet labeled age requirements for the medication;
3. If request is for a step therapy medication, member must meet the following:
    a. Documentation of the inability of the member and/or caregiver to reconstitute and administer a preferred glucagon product in a timely fashion, unless member meets one of the following (i, ii, or iii);
        i. Allergy to medications not requiring prior approval;
        ii. Contraindication to or drug interaction with medications not requiring prior approval;

iii. History of unacceptable/toxic side effects to medications not requiring prior approval;

4. If request is for a non-preferred medication, member must meet all of the following (a and b):
   a. Failure of step therapy medication, unless member meets one of the following (i, ii, or iii);
      i. Allergy to medications not requiring prior approval;
      ii. Contraindication to or drug interaction with medications not requiring prior approval;
      iii. History of unacceptable/toxic side effects to medications not requiring prior approval;
   b. Documentation of the inability of the member and/or caregiver to reconstitute and administer a preferred glucagon product in a timely fashion, unless member meets one of the following (i, ii, or iii);
      i. Allergy to medications not requiring prior approval;
      ii. Contraindication to or drug interaction with medications not requiring prior approval;
      iii. History of unacceptable/toxic side effects to medications not requiring prior approval;
5. Request does not exceed 2 packs/syringes per month.

Approval Duration: 12 months

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

III. Appendices/General Information

Appendix A: Abbreviation Key

FDA: Food and Drug Administration
GI: gastrointestinal
MRI: Magnetic Resonance Imaging

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
GlucaGen® (glucagon)	**Severe hypoglycemia:** Diabetes Mellitus:	Children and Adolescents weighing 25 kg or more and Children 6 years and

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Adults: 1 mg administered IM, IV, or subcutaneously. Additional doses may be given while waiting for emergency assistance. IV dextrose must be administered if the patient fails to respond to glucagon. Once patient responds to treatment, give oral carbohydrates to prevent recurrence of hypoglycemia. *Children and Adolescents weighing 25 kg or more and Children 6 years and older with unknown weight:* 1 mg IM, IV, or subcutaneously once. If no response is seen within 15 minutes, may repeat dose up to a total of 3 doses. IV dextrose must be administered if the patient fails to respond to glucagon. Once patient responds to treatment, give oral carbohydrates to prevent recurrence of hypoglycemia. *Infants and Children weighing less than 25 kg and Children younger than 6 years with unknown weight:* 0.5 mg IM, IV, or subcutaneously once. If no response is seen within 15 minutes, may repeat dose up to a total of 3 doses. IV dextrose must be administered if the patient fails to respond to glucagon. Once patient responds to treatment, give oral carbohydrates to prevent recurrence of hypoglycemia.	older with unknown weight and Adults: 1 mg/dose Infants and Children weighing less than 25 kg and Children younger than 6 years with unknown weight: 0.5 mg/dose

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Glucagon	**Severe hypoglycemia:** Diabetes Mellitus: *Adults:* 1 mg administered IM, IV, or subcutaneously. Additional doses may be given while waiting for emergency assistance. IV dextrose must be administered if the patient fails to respond to glucagon. Once patient responds to treatment, give oral carbohydrates to prevent recurrence of hypoglycemia. *Children and Adolescents weighing 20 kg or more:* 1 mg IM, IV, or subcutaneously once. If no response is seen within 15 minutes, may repeat dose up to a total of 3 doses. IV dextrose must be administered if the patient fails to respond to glucagon. Once patient responds to treatment, give oral carbohydrates to prevent recurrence of hypoglycemia. *Infants and Children weighing less than 20 kg:* 0.02 to 0.03 mg/kg/dose or 0.5 mg/dose IM, IV, or subcutaneously once. If no response is seen within 15 minutes, may repeat dose up to a total of 3 doses. IV dextrose must be administered if the patient fails to respond to glucagon. Once patient responds to treatment, give oral carbohydrates to prevent recurrence of hypoglycemia.	Children and Adolescents weighing 20 kg or more and Adults: 1mg/dose Infants and Children weighing less than 20 kg: 0.02 to 0.03 mg/kg/dose or 0.5 mg/dose Neonates: 1 mg/dose is the maximum dose typically used; however, indication and clinical response determine dosage titration. Psychotic patients receiving insulin shock therapy: Adults: 0.5 to 1 mg/dose Diagnostic aide in radiographic examination and MRI of GI tract: Adults: ranges from 0.2 mg to 2 mg/dose

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Neonates: 0.2 mg/kg/dose IM, IV, or subcutaneously (Max: 1 mg/dose) is commonly used although there is variability in clinical practice; doses of 0.003 to 0.3 mg/kg/dose have been reported in the literature. If no response within 15 minutes, the dose may be repeated. Of note, FDA-approved product labeling does not provide specific recommendations for neonatal dosing, and there is wide variance between the doses reported in the literature and pediatric doses recommended by the product labeling. In addition, recommendations from product labeling vary by specific product. For glucagon (recombinant by Eli Lilly), 0.02 to 0.03 mg/kg/dose or 0.5 mg/dose for patients weighing less than 20 kg is the recommended dose. Psychotic patients receiving insulin shock therapy: *Adults:* 0.5 to 1 mg of glucagon IM or IV after 1 hour of coma. If patient does not awaken after 10 to 25 minutes, the dose may be repeated. For patients in a deep state of coma, IV dextrose should be administered in addition to glucagon for a more immediate response.	

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Diagnostic aide in radiographic examination and MRI of GI tract: *Adults:* ranges from 0.2 mg to 2 mg depending on the diagnostic technique and route of glucagon administration. The usual diagnostic dose for relaxation of the stomach, duodenal bulb, duodenum, and small bowel is 0.2 mg to 0.5 mg IV OR 1 mg IM; the usual dose to relax the colon is 0.5 mg to 0.75 mg IV OR 1 mg to 2 mg IM. After the end of the diagnostic procedure, give oral carbohydrates to patients who have been fasting.	

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - diagnosis or suspected diagnosis of an insulinoma
  - Pheochromocytoma
- Boxed warning(s): none reported

IV. Dosage and Administration

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Baqsimi® (glucagon)	**Severe hypoglycemia:** Diabetes mellitus: *Children 4 years and older and Adults:* 1 actuation (3mg/dose) into 1 nostril. Instruct patients to seek medical attention immediately after administration of the first dose. May repeat 3 mg dose if there has been no response after 15 minutes; do not administer more than 2 sequential doses unless under direct medical supervision.	3 mg/dose
Gvoke HypoPen® and Gvoke PFS® (glucagon)	**Severe hypoglycemia:** Diabetes mellitus: *Children 2 to 12 years weighing 45 kg or more, Adolescents, and Adults:* 1 mg subcutaneously. Instruct patients to seek medical attention immediately after administration of the first dose. May repeat 1 mg dose if there has been no response after 15 minutes; do not administer more than 2 sequential doses unless under direct medical supervision. *Children 2 to 12 years weighing less than 45 kg:* 0.5 mg subcutaneously. Instruct patients to seek medical attention immediately after administration of the first dose. May repeat 0.5 mg dose if there has been no response after 15 minutes; do not administer more than 2 sequential doses unless under direct medical supervision.	Children 2 to 12 years weighing 45 kg or more, Adolescents, and Adults: 1 mg/dose Children 2 to 12 years weighing less than 45 kg: 0.5 mg/dose

For preferred agents please see Appendix B.

V. Product Availability

Drug	Availability
Baqsimi® (glucagon)	Nasal device: 3mg (one pack and two pack)
GlucaGen® (glucagon)	Vial: 1mg/ml (10-pack, diagnostic kit, and Hypokit)
Glucagon emergency kit	Powder for injection: 1 mg
Gvoke® (glucagon)	Auto-injector (HypoPen): 0.5mg/0.1ml, 1mg/0.2ml (one pack and two pack) Pre-filled syringe (PFS): 0.5mg/0.1ml, 1mg/0.2ml (one pack and two pack)

VI. References
Refer to package inserts.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created	11/20	

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.