Clinical Policy: Cardiovascular Agents: Pulmonary Arterial Hypertension

Reference Number: OH.PHAR.PPA.32
Effective Date: 01/01/2020
Last Review Date: N/A
Line of Business: Medicaid

Coding Implications
Revision Log

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

Description

FDA Approved Indication(s): Varies by drug product, please see package insert; clinical pharmacology or other appropriate clinical reference.

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.

NOTE – Grandfathering: Members who have a claim for a non-preferred drug in the previous 120 days will be automatically approved to continue the drug through the automated PA system. Members who have taken the drug in the previous 120 days, but do not have claims history (e.g. new to Medicaid), will be approved for PA after prescriber contact.

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Phosphodiesterase-5 Inhibitor, Oral

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
REVATIO® oral solution (sildenafil) (no PA for age under 6) SILDENAFIL (generic of Revatio®) TADALAFIL (generic for Adcirca®)	REVATIO® oral solution (sildenafil) (PA required for age over 6)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Endothelin Receptor Antagonist, Oral

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
AMBRISENTAN (generic for Letairis®) TRACLEER® (bosentan)	OPSUMIT® (macitentan) TRACLEER® Susp (bosentan)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Prostacyclin Analog, Oral

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	ORENITRAM® (treprostinil diolamine)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Prostacyclin Receptor Agonist, Oral

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	UPTRAVI® (selexipag)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Guanylate Cyclase Stimulators, Oral

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	ADEMPAS® (riociguat)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION, Prostacyclin Analog, Inhaled

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	TYVASO® (treprostinil) VENTAVIS® (iloprost)

CARDIOVASCULAR AGENTS: PULMONARY ARTERIAL HYPERTENSION Prostacyclin Analog, Intravenous

CLINICAL PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
	EPOPROSTENOL (generic of Flolan®) REMODULIN® (treprostinil sodium) VELETRI® (epoprostenol)

It is the policy of Buckeye Health Plan, an affiliate of Centene Corporation®, that are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria Oral agents

A. Diagnosis of pulmonary arterial hypertension

1. Member must meet labeled age requirements for the medication;
2. Documentation that there has been therapeutic failures to no less than a 30 day trial with at least two medications, one of which is a Phosphodiesterase-5 Inhibitor, not requiring prior approval unless one of the following (a,b, or c)
    a. Allergy to all medications not requiring prior approval
    b. Contraindication to all medications not requiring prior approval
    c. History of unacceptable/toxic side effects to medications not requiring prior approval

Approval duration: 12 months.

3. **Diagnosis of CTEPH: (WHO group 4)**
    a. Disease is inoperable or persistent (i.e., suboptimal surgical outcome);
    b. Prescribed medication is **Riociguat (Adempas)**

Approval duration: 12 months.

II. Initial approval inhaled or intravenous agents Epoprostenol (Flolan); Remodulin(treprostinil sodium); Veletri (epoprostenol)

A. Diagnosis of pulmonary arterial hypertension (member meets the following)

1. Member diagnosed as World Health Organization Group 3 or more severe

Approval duration: 12 months.

III. 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.

IV. Appendices/General Information

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.

*****See above tables for preferred alternatives***** *Dosing varies by drug product. See FDA approved dosing and administration.*

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

- See package insert; clinical pharmacology or other appropriate clinical reference

V. Dosage and Administration: varies by drug product. See package insert; clinical pharmacology or other appropriate clinical reference for FDA approved dosing and administration

VI. Product Availability: See package insert; clinical pharmacology or other appropriate clinical reference for product availability

VII. References. Refer to package insert.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created.	10.19	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.