Clinical Policy: Lifitegrast (Xiidra)
Reference Number: CP.PMN.73
Effective Date: 11.01.16
Last Review Date: 11.19
Line of Business: Medicaid

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

Description
Lifitegrast (Xiidra®) is a lymphocyte function-associated antigen-1 antagonist.

FDA Approved Indication(s)
Xiidra is indicated for the treatment of the signs and symptoms of dry eye disease (DED).

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 Xiidra is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Dry Eye Disease (must meet all):
      1. Diagnosis of DED;
      2. Age ≥ 17 years;
      3. Failure of 2 artificial tear products containing different active ingredients, each used for ≥ 4 weeks, unless contraindicated or clinically significant adverse effects are experienced;
      4. Dose does not exceed 2 drops per day in each eye (1 box per 30 days).
      Approval duration: 12 months

   B. Other diagnoses/indications
      1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

II. Continued Therapy
   A. Dry Eye Disease (must meet all):
      1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
      2. Member is responding positively to therapy;
      3. If request is for a dose increase, new dose does not exceed 2 drops per day in each eye (1 box per 30 days).
      Approval duration: 12 months
B. Other diagnoses/indications (must meet 1 or 2):
   1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy. 
      Approval duration: Duration of request or 12 months (whichever is less); or
   2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): 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.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   DED: dry eye disease
   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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artificial tear products*</td>
<td>Solution/gel: 1-2 drops into the affected eye(s) 2-4 times/day as needed</td>
<td>Not applicable</td>
</tr>
<tr>
<td>• Refresh P.M.®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Systane® Nighttime</td>
<td></td>
<td></td>
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<tr>
<td>• Nature’s Tears®</td>
<td></td>
<td></td>
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<tr>
<td>• Artificial Tears</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lacri-Lube®</td>
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</tr>
</tbody>
</table>

   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.

*Available over-the-counter in a number of preparations. This list is not all-inclusive

   Appendix C: Contraindications/Boxed Warnings
   • Contraindication(s): hypersensitivity
   • Boxed warning(s): none reported

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>DED</td>
<td>Instill 1 drop BID in each eye (~12 hours apart)</td>
<td>2 drops/eye/day</td>
</tr>
</tbody>
</table>
VI. Product Availability
Ophthalmic solution containing lifitegrast 5% (50 mg/mL): 0.2 mL containers (60 single-use containers/box)

VII. References

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guideline created.</td>
<td>08.16</td>
<td>11.16</td>
</tr>
<tr>
<td>-Added age and quantity limit; verified references.</td>
<td>07.01.17</td>
<td>11.17</td>
</tr>
<tr>
<td>4Q 2018 annual review: no significant changes; initial approval duration increased to 12 months; references reviewed and updated.</td>
<td>07.03.18</td>
<td>11.18</td>
</tr>
<tr>
<td>4Q 2019 annual review: no significant changes; references reviewed and updated.</td>
<td>08.24.19</td>
<td>11.19</td>
</tr>
</tbody>
</table>

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.

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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.

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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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