Drug Therapy Guidelines

Applicable Pulmonary Arterial Hypertension (PAH) Agents: Revatio™ (sildenafil), Ventavis® (iloprost), Tracleer® (bosentan), Letairis™ (ambrisentan), Adcirca® (tadalafil), Tyvaso® (treprostinil), Remodulin® (treprostinil), Flolan®/Veletri® (epoprostenol), Adempas® (riociguat), Opsumit® (macitentan), Orenitram® (treprostinil), Uptravi® (selexipag)

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<tr>
<th>Medical Benefit</th>
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<th>Effective: 1/1/17</th>
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<td>Pharmacy- Formulary 1</td>
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<td>Next Review: 12/17</td>
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<td>Pharmacy- Formulary 2</td>
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<td>Date of Origin: 5/28/06</td>
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I. Medication Description

Pulmonary Arterial Hypertension (PAH) is a condition characterized by unusually high and persistent pulmonary artery pressure. Common symptoms patients initially experience are shortness of breath, fatigue, and fainting. As the disease progresses, symptoms become more acute and patients may develop cyanosis, edema, and angina. The disease is progressive and can lead to right-sided heart failure and death. Several biological drug targets have been identified as mechanisms involved in PAH. Phosphodiesterase-5 inhibitors inhibit a specific phosphodiesterase enzyme found in the smooth muscle of the pulmonary vasculature, thus resulting in a relaxation of pulmonary smooth muscles and ultimately, a decrease in resistance. Prostacyclin analogs decrease pulmonary vascular resistance by taking advantage of the vasodilatory effects of this prostaglandin. Endothelial-receptor antagonists block endothelin’s ability to bind to receptors on lung blood vessels, thus preventing constriction of these vessels. Soluble guanylate cyclase stimulators decrease vascular tone independent of nitric oxide.

II. Position Statement

Coverage is determined through a prior authorization process with supporting clinical documentation for every request.

All medications in this policy may be covered under the pharmacy benefit if they are self-administered. Flolan, Veletri, Remodulin, Ventavis may also be covered under the medical benefit if they are administered by a healthcare professional.

III. Policy

Coverage of the pulmonary arterial hypertension agents in this policy is provided in accord with the following:

- For Pulmonary Arterial Hypertension (all agents in this policy):
  - Patient is followed by a cardiologist or pulmonologist AND
  - Patient has been evaluated with a right heart catheterization AND
  - Patient is diagnosed with pulmonary arterial hypertension (WHO Group 1) based on the following:
• Mean pulmonary arterial pressure (mPAP) greater than 25mm Hg AND
• Pulmonary capillary wedge pressure (PCWP) or pulmonary artery occlusion pressure (PAOP) less than or equal to 15mm Hg AND
• Pulmonary vascular resistance (PVR) greater than 3 Wood units AND

• For Chronic Thromboembolic Pulmonary Hypertension (Adempas only):
  o Patient is followed by a cardiologist or pulmonologist AND
  o Patient has been evaluated with a ventilation-perfusion (VQ) scan AND
  o Patient is diagnosed with chronic thromboembolic pulmonary hypertension with the following signs/symptoms:
    ▪ Chest discomfort/angina, fatigue, lightheadedness, or syncope AND
    ▪ Pulmonary flow murmur or bruit OR
    ▪ History of recurrent pulmonary emboli

IV. Quantity Limitations

• Revatio: 90 tablets per 30 days
• Adcirca: 60 tablets per 30 days
• Flolan: Individualized per patient.
• Veletri: Individualized per patient.
• Remodulin: Individualized per patient.
• Tyvaso®: 1 box of 28 ampules per 28 days.
• Ventavis: 270 ampules per 30 days.
• Letairis: 30 tablets per 30 days.
• Tracleer:
  o 62.5mg: 60 tablets per 30 days
  o 125mg: 60 tablets per 30 days
• Adempas: 90 tablets per 30 days
• Opsumit: 30 tablets per 30 days
• Orenitram: Individualized per patient.
• Uptravi
  o Titration (first two months): up to 140 x 200mcg tabs per month and one titration pack
  o Maintenance: (each individual strength): 60 tablets per 30 days

V. Coverage Duration

Coverage will be granted indefinitely through the life of this policy once the initial criteria are met.

VI. Coverage Renewal Criteria

n/a
VII. Billing/Coding Information

- Pertinent indications: I27.0, I27.2
- Revatio:
  - 20mg tablets
  - Pharmacy benefit
- Flolan:
  - J1325 (each billable unit = 0.5 mg)
  - 0.5mg, 1.5mg powder for injection
  - Medical benefit when administered by a healthcare professional
  - Pharmacy benefit when self-administered
- Veletri:
  - J1325 (each billable unit = 0.5mg)
  - 0.5mg, 1.5mg powder for injection
  - Medical benefit when administered by a healthcare professional
  - Pharmacy benefit when self-administered
- Remodulin:
  - J3285 (each billable unit = 1 mg)
  - 1mg/ml, 2.5mg/ml, 5mg/ml, and 10mg/ml vials for continuous SC infusion
  - Medical benefit when administered by a healthcare professional
  - Pharmacy benefit when self-administered
- Ventavis:
  - Q4074 (each billable unit = up to 20mcg)
  - 10mcg/ml or 20mcg/ml ampules (1 ml each)
  - Medical benefit when administered by a healthcare professional
  - Pharmacy benefit when self-administered
- Tyvaso:
  - 0.6mg/ml ampules for inhalation
  - Pharmacy benefit
- Tracleer:
  - 62.5mg, 125mg oral tablets
  - Pharmacy benefit
- Letairis:
  - 5mg, 10mg oral tablets
  - Pharmacy benefit
- Adcirca:
  - 20mg oral tablets
  - Pharmacy benefit
- Adempas:
  - 0.5mg, 1mg, 1.5mg, 2mg, 2.5mg oral tablets
  - Pharmacy benefit
- Opsumit®:
  - 10mg oral tablets
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Last Review Date: 12/2016

- Pharmacy benefit
  - Orenitram®
    - 0.125mg, 0.25mg, 1mg, 2.5mg oral tablets
    - Pharmacy benefit
  - Uptravi®
    - 200mcg, 400mcg, 600mcg, 800mcg, 1000mcg, 1200mcg, 1400mcg, and 1600mcg oral tablets;
      Titration pack
    - Pharmacy benefit

VIII. Summary of Policy Changes

- 1/1/12:
  - Addition of Veletri to policy
  - Removal of Black Box Warning from Letairis
  - Implement PA reviews of Ventavis, Flolan, and Veletri
- 9/15/12: Longer approval duration applies
- 12/15/12:
  - Requirement of hemodynamic diagnostic testing results and right heart catheterization added for
    initial coverage
  - Warnings edited (reference to full prescribing information made)
  - Coverage of Revatio limited to patients who are at least 18 years of age
- 12/15/13:
  - Flolan/Veletri pharmacy coverage provided
  - Adempas and Opsumit added to policy
- 3/31/14: restriction of Revatio to patients aged 18 and older removed
- 6/15/14: Orenitram added to policy
- 1/1/15: Veletri 0.5mg added to policy
- 7/1/15: formulary distinctions made
- 3/15/16: addressed Tracleer 125mg quantity limits of 60/month; Uptravi added to policy text
- 11/15/16: updated quantity limits for Orenitram to allow for appropriate titration dosing
- 1/1/17: no policy changes
- 8/25/17: clarification on Uptravi titration coverage added

IX. References

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3. Facts and Comparisons Online, retrieved October 2010
4. Barst RJ; Rubin LJ; Long WA; McGoon MD; Rich S; Badesch DB; Groves BM; Tapson VF; Bourge RC; Brundage
   BH; et al. A comparison of continuous intravenous epoprostenol (prostacyclin) with conventional therapy for
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5. Simonneau G; Barst RJ; Galie N; Naeije R; Rich S; Bourge RC; Keogh A; Oudiz R; Frost A; Blackburn SD; Crow JW; Rubin LJ. Continuous subcutaneous infusion of treprostinil, a prostacyclin analogue, in patients with pulmonary arterial hypertension: a double-blind, randomized, placebo-controlled trial. Am J Respir Crit Care Med 2002 Mar 15;165(6):800-4.

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13. Revatio™ package insert, revised 5/2015

14. Adcirca® package insert, revised 7/2015

15. Flolan® package insert, revised 4/2015

16. Remodulin® package insert, revised 12/2014

17. Tyvaso® package insert, revised 6/2016

18. Ventavis® package insert, revised 11/2013

19. Tracleer® package insert, revised 12/2015

20. Letairis™ package insert, revised 10/2015


23. Adempas® package insert, revised 9/2014

24. Opsumit® package insert, revised 10/2013


27. Uptravi® package insert, revised 12/2015

The Plan fully expects that only appropriate and medically necessary services will be rendered. The Plan reserves the right to conduct pre-payment and post-payment reviews to assess the medical appropriateness of the above-referenced therapies.

Drug therapy initiated with samples will not be considered as meeting medical necessity for coverage for non-preferred or prior authorized medications.
The preceding policy applies only to members for whom the above named pharmacy benefit medications are included on their covered formulary. Members with closed formulary benefits are subject to trying all appropriate formulary alternatives before a coverage exception for a non-formulary agent will be considered.

The preceding policy is a guideline to allow for coverage of the pertinent medication/product, and is not meant to serve as a clinical practice guideline.