

Clinical Policy: Treprostinil (Remodulin)

Reference Number: LA.PHAR.199

Effective Date: 09.29.23

Last Review Date: 03.06.25

Line of Business: Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description

Treprostinil (Remodulin®) is a prostacyclin analog.

FDA Approved Indication(s)

Remodulin is indicated for the treatment of pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1) to improve exercise ability.

- Remodulin is also indicated to reduce the rate of clinical deterioration in patients with PAH requiring transition from epoprostenol (Flolan®, Veletri®). The risks and benefits of each drug should be carefully considered prior to transition.

For PAH, studies establishing effectiveness included predominately patients with New York Heart Association (NYHA) Functional Class II-IV symptoms and etiologies of idiopathic or heritable PAH, PAH associated with congenital systemic-to-pulmonary shunts, or PAH associated with connective tissue diseases. Nearly all controlled clinical experience with inhaled treprostinil has been on a background of bosentan (an endothelin receptor antagonist) or sildenafil (a phosphodiesterase type 5 inhibitor) with study duration of 12 weeks.

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 Louisiana Healthcare Connections® that treprostinil is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Pulmonary Arterial Hypertension (must meet all):

1. Diagnosis of PAH;
2. Prescribed by or in consultation with a cardiologist or pulmonologist;
3. Failure of a calcium channel blocker (*see Appendix B*), unless member meets one of the following (a or b):
 - a. Inadequate response or contraindication to acute vasodilator testing;
 - b. Contraindication or clinically significant adverse effects to calcium channel blockers are experienced;
4. If request is for brand Remodulin, member must use generic treprostinil, unless contraindicated or clinically significant adverse effects are experienced;

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- a. Provider must submit treatment plan detailing pump rate, dose, quantity (in mL), and frequency of cassette change;

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: LA.PMN.53 for Medicaid.

II. Continued Therapy

A. Pulmonary Arterial Hypertension (must meet all):

1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. Member must use generic treprostinil, unless contraindicated or clinically significant adverse effects are experienced;
4. Request meets one of the following:
 1. Remodulin: Provider must submit treatment plan detailing pump rate, dose, quantity (in mL) and frequency of cassette change;

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53.

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 policy – LA.PMN.53.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CTEPH: chronic thromboembolic

pulmonary hypertension

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FC: functional class
 FDA: Food and Drug Administration
 FVC: forced vital capacity
 mPAP: mean pulmonary arterial pressure
 NYHA: New York Heart Association
 PA: physical ability

PAH: pulmonary arterial hypertension
 PCWP: pulmonary capillary wedge pressure
 PH: pulmonary hypertension
 PVR: pulmonary vascular resistance
 WHO: World Health Organization
 WU: Wood Units

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
nifedipine (Adalat [®] CC, Procardia XL [®]) [†]	30 mg PO QD; may increase to 60 to 120 mg BID	240 mg/day
diltiazem (Dilt-XR [®] , Cardizem [®] CD, Cartia XT [®] , Tiazac [®] , Cardizem [®] LA, Matzim [®] LA) [†]	60 mg PO BID; may increase to 120 to 360 mg BID	720 mg/day
amlodipine (Norvasc [®]) [†]	5 mg PO QD; may increase to 15 to 30 mg/day	30 mg/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.

[†]Off-label

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warnings(s): none reported

Appendix D: Pulmonary Hypertension: WHO Classification

- Group 1: PAH
- Group 2: PH due to left heart disease
- Group 3: PH due to lung disease and/or hypoxemia
- Group 4: CTEPH
- Group 5: PH due to unclear multifactorial mechanisms

Appendix E: Pulmonary Hypertension: WHO/NYHA Functional Classes (FC)

Treatment Approach*	FC	Status at Rest	Tolerance of Physical Activity (PA)	PA Limitations	Heart Failure
Monitoring for progression of	I	Comfortable at rest	No limitation	Ordinary PA does not cause undue dyspnea	

Treatment Approach*	FC	Status at Rest	Tolerance of Physical Activity (PA)	PA Limitations	Heart Failure
PH and treatment of co-existing conditions				or fatigue, chest pain, or near syncope.	
Advanced treatment of PH with PH-targeted therapy – <i>see Appendix F**</i>	II	Comfortable at rest	Slight limitation	Ordinary PA causes undue dyspnea or fatigue, chest pain, or near syncope.	
	III	Comfortable at rest	Marked limitation	Less than ordinary PA causes undue dyspnea or fatigue, chest pain, or near syncope.	
	IV	Dyspnea or fatigue may be present at rest	Inability to carry out any PA without symptoms	Discomfort is increased by any PA.	Signs of right heart failure

*PH supportive measures may include diuretics, oxygen therapy, anticoagulation, digoxin, exercise, pneumococcal vaccination. **Advanced treatment options also include calcium channel blockers.

Appendix F: Pulmonary Hypertension: Targeted Therapies

Mechanism of Action	Drug Class	Drug Subclass	Drug	Brand/Generic Formulations
Reduction of pulmonary arterial pressure through vasodilation	Prostacyclin* pathway agonist	Prostacyclin	Epoprostenol	Velettri (IV) Flolan (IV) Flolan generic (IV)
	<i>*Member of the prostanoid class of fatty acid derivatives.</i>	Synthetic prostacyclin analog	Treprostinil	Orenitram (oral tablet) Remodulin (IV) Tyvaso, Tyvaso DPI (inhalation)
			Iloprost	Ventavis (inhalation)
		Non-prostanoid prostacyclin receptor (IP receptor) agonist	Selexipag	Uptravi (oral tablet)
	Endothelin receptor antagonist (ETRA)	Selective receptor antagonist	Ambrisentan	Letairis (oral tablet)
		Nonselective dual action receptor antagonist	Bosentan	Tracleer (oral tablet)
			Macitentan	Opsumit (oral tablet)

Mechanism of Action	Drug Class	Drug Subclass	Drug	Brand/Generic Formulations
	Nitric oxide-cyclic guanosine monophosphate enhancer	Phosphodiesterase type 5 (PDE5) inhibitor	Sildenafil	Revatio (IV, oral tablet, oral suspension)
			Tadalafil	Adcirca (oral tablet)
		Guanylate cyclase stimulant (sGC)	Riociguat	Adempas (oral tablet)

V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Treprostinil (Remodulin)	1.25 ng/kg/min SC or IV; can be increased weekly based on clinical response	Based on weight and tolerability

VI. Product Availability

Drug	Availability
Treprostinil (Remodulin)	20 mL vials: 20 mg, 50 mg, 100 mg, 200 mg

VII. References

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Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J3285	Injection, treprostinil, 1mg

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Policy created	05.09.23	08.28.23
Annual review: no significant changes; clarified wording surrounding the preference for generic Remodulin; references reviewed and updated.	04.28.24	07.10.24
Annual review: no significant changes; in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens; clarified drugs used for off-label indications; references reviewed and updated	03.06.25	

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. LHCC 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.

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 LHCC administrative policies and procedures.

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