Clinical Policy: Rifapentine (Priftin)

Reference Number: CP.PMN.05
Effective Date: 02.01.16
Last Review Date: 02.18
Line of Business: Medicaid

Revision Log

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

Description

Rifapentine (Priftin®) is a cyclopentyl rifamycin antimycobacterial agent.

FDA Approved Indication(s)

Priftin is indicated for:

- Patients 12 years of age and older for the treatment of active pulmonary tuberculosis (TB) caused by Mycobacterium tuberculosis (*M. tuberculosis*) in combination with one or more anti-tuberculosis drugs to which the isolate is susceptible
- The treatment of latent tuberculosis infection (LTBI) caused by *M.tuberculosis* in combination with isoniazid in patients 2 years of age and older at high risk of progression to TB disease.

Limitation(s) of use:

- Do not use Priftin monotherapy in either the initial or the continuation phases of active antituberculous treatment. Priftin should not be used once-weekly in the continuation phase regimen in combination with isoniazid in HIV-infected patients with active TB because of a higher rate of failure and/or relapse with rifampin-resistant organisms. Priftin has not been studied as part of the initial phase treatment regimen in HIV-infected patients with active pulmonary tuberculosis
- Active tuberculosis disease should be ruled out before initiating treatment for latent tuberculosis infection. Priftin must always be used in combination with isoniazid as a 12-week once-weekly regimen for the treatment of latent tuberculosis infection. Priftin in combination with isoniazid is not recommended for individuals presumed to be exposed to rifamycin- or - isoniazid resistant *M. tuberculosis*.

Policy/Criteria

Provider must submit documentation (including 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 Priftin is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Active Pulmonary Tuberculosis (must meet all)**:**

1. Diagnosis of TB;
2. Age ≥ 12 years;

3. Prescribed in combination with one or more anti-tuberculosis drugs (e.g., isoniazid, rifampin, pyrazinamide, ethambutol);
4. Member is not HIV positive;
5. Dose does not exceed the following:
   a. Induction phase of treatment: 600 mg twice weekly for 2 months;
   b. Continuation phase: 600 mg once weekly for 4 months

Approval duration: 6 months

B. Latent Tuberculosis Infection (must meet all)**:**
1. Diagnosis of LTBI;
2. Age ≥ 2 years;
3. Failure of ≥ 9 month trial of isoniazid at maximum indicated dose;
4. Prescribed in combination with isoniazid;
5. Dose does not exceed 900 mg weekly (6 tablets/week).

Approval duration: 12 weeks

C. Other diagnoses/indications
1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. Active Pulmonary Tuberculosis (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member has not received up to 6 months of therapy;
3. Prescribed in combination with one or more anti-tuberculosis drugs (e.g. isoniazid, rifampin, pyrazinamide, ethambutol);
4. If request is for a dose increase, new dose does not exceed the following:
   a. Induction phase of treatment: 600 mg twice weekly for 2 months;
   b. Continuation phase: 600 mg once weekly for 4 months.

Approval duration: Approve up to 6 months of total treatment

B. Latent Tuberculosis Infection (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member has not received up to 12 weeks of therapy;
3. Prescribed in combination with isoniazid;
4. Dose does not exceed 900 mg weekly (6 tablets/week).

Approval duration: Approve up to 12 weeks of total treatment

C. 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 CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

HIV: human immunodeficiency virus
INH: isoniazid
LTBI: latent tuberculosis infection
M. tuberculosis: Mycobacterium tuberculosis
DOT: directly observed therapy
RIF: rifampin

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
isoniazid (Nydrazid)	5 mg/kg up to 300 mg daily in a single dose or 15 mg/kg up to 900 mg/day, two or three times/week	300 mg/day daily or 900 mg/day for twice weekly therapy

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.

V. Dosage and Administration

<table>
<tr><th>Indication</th><th>Dosing Regimen</th><th>Maximum Dose</th></tr>
<tr><td>Active Pulmonary Tuberculosis</td><td>
<table>
<tr><td>Phase of Administration</td><td>Length</td><td>Dosage</td></tr>
<tr><td>Initial</td><td>2 months</td><td>600 mg twice weekly for two months as directly observed therapy (DOT), with no less than 72 hours between doses, in combination with other anti-tuberculosis drugs</td></tr>
<tr><td>Continuation</td><td>4 months</td><td>600 mg once-weekly for 4 months as DOT with isoniazid or another appropriate anti-tuberculosis agent</td></tr>
</table>
</td><td>900 mg/dose</td></tr>
<tr><td>Latent Tuberculosis Infection</td><td>In combination with isoniazid once-weekly for 12 weeks as directly observed therapy.</td><td>900 mg/dose</td></tr>
</table>

Indication	Dosing Regimen	Maximum Dose
	Adults and children ≥ 12 years: Priftin (based on weight, see table below) and isoniazid 15 mg/kg (900 mg maximum) Children 2–11 years: Priftin (based on weight, see table below) and isoniazid 25 mg/kg (900 mg maximum)	

Weight Range	Priftin Dose	Number of Priftin tablets
10–14 kg	300 mg	2
14.1–25 kg	450 mg	3
25.1– 32 kg	600 mg	4
32.1–50 kg	750 mg	5
> 50 kg	900 mg	6

VI. Product Availability

Tablet: 150 mg

VII. Workflow Document

Not available.

VIII. References

1. Priftin prescribing information. Bridgewater, NJ: Sanofi-Aventis U.S. LLC; August 2017. Available at: http://products.sanofi.us/. Accessed October 2017.
2. Centers for Disease Control and Prevention. Recommendations for use of isoniazid-rifapentine regimen with direct observation to treat latent mycobacterium tuberculosis infection: United States, 2011.MMWR Morb Mortal Wkly Rep 2011;60(48);1650-1653.
3. Centers for Disease Control and Prevention. Treatment of tuberculosis, American Thoracic Society, CDC, and Infectious Diseases Society of America. MMWR 2003;52(No. RR-11):1-77.
4. Nahid P, Dorman SE, Alipanah N et al. Official American Thoracic Society/Centers for Disease Control and Prevention/Infectious Diseases Society of America Clinical Practice Guidelines: Treatment of Drug-Susceptible Tuberculosis. Clin Infect Dis. 2016 Oct 1;63(7):e147-95. doi: 10.1093/cid/ciw376. Epub 2016 Aug 10.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	01.16	02.16
Updated to integrated template; removed age requirement it is not an absolute contraindications per FDA labeling; added examples of anti-tuberculosis drugs; added ≥ 9 month trial of isoniazid for latent TB infection due to CDC and Uptodate recommendations.	11.16	02.17
1Q18 annual review: -No significant changes - References reviewed and updated.	11.13.17	02.18

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.

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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.