Clinical Policy: Levalbuterol (Xopenex HFA/Inhalation Solution)

Reference Number: CP.PMN.07
Effective Date: 09.01.06
Last Review Date: 02.19
Line of Business: HIM, Medicaid

Revision Log

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

Description

Levalbuterol (Xopenex®) is a beta$_2$-adrenergic agonist.

FDA Approved Indication(s)

Xopenex HFA is indicated for the treatment or prevention of bronchospasm in adults, adolescents, and children 4 years of age and older with reversible obstructive airway disease.

Xopenex inhalation solution is indicated for the treatment or prevention of bronchospasm in adults, adolescents, and children 6 years of age and older with reversible obstructive airway disease.

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 Xopenex is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Request for Xopenex HFA/Inhalation Solution (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Presence of cardiac disease;
   b. Member experienced clinically significant adverse effects from albuterol use within the last 90 days;
2. Member does NOT have history of allergy or hypersensitivity to albuterol or levalbuterol;
3. Request does not exceed:
   a. Xopenex HFA: 2 inhalers per 30 days;
   b. Xopenex inhalation solution: 4 vials per day (12 mL per day).

Approval duration: 6 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): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Request for Xopenex HFA/Inhalation Solution (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. Albuterol has not been used within the past 3 months as evidenced by pharmacy claims history;
4. If request is for a dose increase, request does not exceed:
   a. Xopenex HFA: 2 inhalers per 30 days;
   b. Xopenex inhalation solution: 4 vials per day (12 mL per day).

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): HIM.PHAR.21 for health insurance marketplace and 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 – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
MDI: metered-dose inhaler

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
albuterol (ProAir HFA®, Proventil HFA®, Ventolin HFA®)	*Metered-dose inhaler [MDI] (e.g., ProAir HFA)*: 2 puffs every 4 to 6 hours as needed *Nebulization solution:* 2.5 mg via oral inhalation every 6 to 8 hours as needed	*MDI*: 12 puffs/day *Nebulization solution*: 4 doses/day or 10 mg/day Higher maximum dosages for inhalation products have been recommended in National

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
		Asthma Education and Prevention Program guidelines for acute exacerbations of asthma.

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

- Contraindication(s): history of hypersensitivity to levalbuterol or racemic albuterol (or any other component of Xopenex HFA inhalation aerosol)
- Boxed warning(s): none reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Treatment or prevention of bronchospasm	*MDI (Xopenex HFA):* 2 puffs every 4 to 6 hours as needed *Nebulization solution*: 0.31 mg to 1.25 mg inhaled via nebulization 3 times per day, given every 6 to 8 hours	*MDI*: 2 puffs every 4 hours; higher doses may be required acutely during severe exacerbations *Nebulization solution*: 1.25 mg/dose 3 times/day

VI. Product Availability

- Inhalation aerosol: 59 mcg of levalbuterol tartrate (equivalent to 45 mcg of levalbuterol free base) per actuation
  - 15 g pressurized canister containing 200 actuations
- Inhalation solution (unit-dose vial for nebulization): 0.31 mg/3 mL, 0.63 mg/3 mL and 1.25 mg/3 mL
- Inhalation solution concentrate: 1.25 mg/0.5 mL

VII. References

1. Xopenex HFA Prescribing Information. Marlborough, MA: Sunovion Pharmaceuticals Inc.; February 2017. Available at: https://dailymed.nlm.nih.gov/dailymed/. Accessed September 25, 2018.
2. Xopenex Inhalation Solution Prescribing Information. Lake Forest, IL: Akorn, Inc.; June 2017. Available at: https://dailymed.nlm.nih.gov/dailymed/. Accessed September 25, 2018.
3. National Heart, Lung, and Blood Institute. Expert panel report 3: guidelines for the diagnosis and management of asthma. National Asthma Education and Prevention Program. Published August 28, 2007. Available from: https://www.nhlbi.nih.gov/files/docs/guidelines/asthgdln.pdf. Accessed September 25, 2018.
4. Nelson HS, Bensch G, Pleskow WW, et al. Improved bronchodilation with levalbuterol compared with racemic albuterol in patients with asthma. J Allergy Clin Immunol. 1998; 102: 943-952.

5. Gawchik SM, Consuelo SL, Noonan M, et al. The safety and efficacy of nebulized levalbuterol compared with racemic albuterol and placebo in the treatment of asthma in pediatric patients. J Allergy Clin Immunol. 1999; 103: 615-21
6. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2018. Available at: http://www.clinicalpharmacology-ip.com/.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added criteria "C" in the "Criteria for Approval" section; Added "using SABA >2 days per week" in "Special Instructions"; Updated Reference section to reflect current literature search and reference documents;	02./13	02./13
No Changes.	02./14	02./14
No Changes.	02./15	02./15
Converted to new template Added requirement for side effect to albuterol use in the last 90 days to criteria for approval	08.15	08.15
Updated Reference section to reflect current literature search	11.15	02.16
Converted to new integrated template; Modified QL of HFA from 1 inhaler/30 days to 2 inhalers/30 days (in line with QL for PDL Ventolin HFA, Proair HFA); specified duration of approval for initial and re-auth criteria; Re-auth: added requirements related to positive response to therapy and albuterol has not been used within the past 3 months as evidenced by pharmacy claims history; Updated references	11.16	02.17
1Q18 annual review: -Policies combined for Centene Medicaid and Marketplace lines of business - No significant changes from previous corporate approved policy - Medicaid: modified QL of inhalation solution from 3 vials/day to 4 vials (12 mL)/day - References reviewed and updated.	10.26.17	02.18
1Q 2019 annual review: no significant change from previously approved policy; references reviewed and updated.	09.25.18	02.19

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.