Clinical Policy: Guanfacine ER (Intuniv)
Reference Number: CP.PMN.37
Effective Date: 04/10
Last Review Date: 08/17 Revision Log
Line of Business: Medicaid

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

Description
Guanfacine (Intuniv®) is a central alpha$_{2A}$ -adrenergic receptor agonist.

FDA approved indication
Intuniv is indicated for the treatment of attention deficit hyperactivity disorder (ADHD) as monotherapy and as adjunctive therapy to stimulant medications.

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Centene Corporation® that Intuniv is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Attention Deficit Hyperactivity Disorder (must meet all)**:**

1. Diagnosis of attention deficit and hyperactivity disorder (ADHD);
2. Age ≥ 6 years;
3. Failure of an amphetamine-based stimulant at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced to any amphetamine product;
4. Failure of a methylphenidate-based stimulant at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced to any methylphenidate product;
5. Failure of a 4 week trial of immediate-release guanfacine dosed two to three times daily unless clinically significant adverse effects are experienced;
6. Request is for once daily dosing;
7. Dose does not exceed the following:
   a. Ages 6-12 years: 4 mg per day;
   b. Age ≥ 13 years: 7 mg/day.

Approval duration: 12 months

B. 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. Attention Deficit Hyperactivity Disorder (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Documentation of positive response to therapy;
3. Request is for once daily dosing;
4. If request is for a dose increase, new dose does not exceed the following:
   a. Ages 6-12 years: 4 mg per day;
   b. Age ≥ 13 years: 7 mg/day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via health plan 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
ADHD: attention deficit hyperactivity disorder
FDA: Food and Drug Administration

Appendix B: General Information
The use of alpha-2 adrenergic receptor agonists (e.g., guanfacine and clonidine) concurrently is not recommended.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
ADHD	1 mg to 7 mg (0.05-0.12 mg/kg target weight based dose range) once daily in the morning or evening based on clinical response and tolerability	Monotherapy: Children 6 to 12 years: 4 mg/day; Adolescents: 13 to 17 years: 7 mg/day Adjunct therapy (with psychostimulants): 4 mg/day

VI. Product Availability

Extended-release tablets: 1 mg, 2 mg, 3 mg and 4 mg

VII. Workflow Document

N/A

VIII. References

1. Intuniv Prescribing Information. Lexington, MA: Shire US Inc.; July 2016. Available at: https://dailymed.nlm.nih.gov/dailymed/. Accessed March 27, 2017.
2. Guanfacine Monograph. Clinical Pharmacology. Accessed March 2017. http://www.clinicalpharmacology-ip.com
3. Pliszka S, AACAP Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry. 2007 Jul; 46(7):894-921.
4. Subcommittee on attention-deficit/hyperactivity disorder, steering committee on quality improvement and management. ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. Pediatrics. 2011;128(5):1007-1022. doi:10.1542/peds.2011-2654.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Added language "at maximized tolerated doses" to stimulant trial. References updated to reflect current literature search.	05/12	05/12
References updated to reflect current literature search. Added warning regarding need for dosage adjustment with CYP3A4 inhibitors and inducers Added warnings regarding substitution of immediate-release guanfacine for long-acting guanfacine without dosage adjustment.	05/13	05/13
Updated references.	05/14	05/14
Updated references.	03/15	03/15
Converted to new template Clarified that ER amphetamine and methylphenidate should be used before Intuniv may be approved.		
Modified criteria to require trial of stimulants at maximum recommended doses; Updated criteria to include intolerance to stimulant agents; Added once daily dosing requirement in accordance with FDA dosing guidelines; Modified specific max quantity limit to generalized FDA max recommended dose and health plan approved QL statement; Updated references to reflect current literature search.	05/16	08/16
Converted to new template. Initial: removed prescriber specialty; modified age restriction	03/17	08/17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
from 6-17 years to Age ≥ 6 years; modified stimulant trials by removing 1) extended release requirement and 2) trial duration of ≥ 2 weeks (with a titration to max dose, member would have trialed the medication for a sufficient timeframe); updated requirement related to immediate-release guanfacine trial to include "unless clinically significant adverse effects are experienced". Re-auth: added efficacy requirement of positive response to therapy per template update. Changed generalized FDA approved maximum recommended dose and health plan approved QL statement to specific max dose based on age per PI; updated references.		

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.