Clinical Policy: Aclidinium/Formoterol (Duaklir Pressair)
Reference Number: CP.PCH.23
Effective Date: 03.01.20
Last Review Date: 08.20
Line of Business: Commercial, HIM

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

Description
Aclidinium/formoterol (Duaklir® Pressair®) is a combination product containing a long-acting anticholinergic (LAMA) and a long-acting beta-2 agonist (LABA).

FDA Approved Indication(s)
Duaklir Pressair is indicated for the maintenance treatment of patients with chronic obstructive pulmonary disease (COPD).

Limitation(s) of use: Duaklir Pressair is not indicated for relief of acute bronchospasm or for the treatment of asthma.

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 Duaklir Pressair is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Chronic Obstructive Pulmonary Disease (must meet all):
      1. Diagnosis of COPD;
      2. Age ≥ 18 years;
      3. Failure of one of the following (a or b) at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced:
         a. One formulary LABA (e.g., Serevent®, Striverdi Respimat®) in combination with one formulary LAMA (e.g., Incruse® Ellipta®, Spiriva® Handihaler®/Respimat®);
         b. One formulary inhaled corticosteroid (ICS) in combination with a formulary LABA (e.g., fluticasone/salmeterol [generic Advair® Diskus®/Wixela™ Inhub™], Breo® Ellipta®, budesonide/formoterol [generic Symbicort®]);
      4. Dose does not exceed 2 inhalations per day (1 inhaler per 30 days).

Approval duration:
HIM – 12 months
Commercial – Length of Benefit
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): CP.CPA.09 for commercial and HIM.PHAR.21 for health insurance marketplace.

II. Continued Therapy
   A. Chronic Obstructive Pulmonary Disease (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. If request is for a dose increase, new dose does not exceed 2 inhalations per day (1 inhaler per 30 days).

   Approval duration:
   HIM – 12 months
   Commercial – Length of Benefit

   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): CP.CPA.09 for commercial and HIM.PHAR.21 for health insurance marketplace.

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 – CP.CPA.09 for commercial and HIM.PHAR.21 for health insurance marketplace or evidence of coverage documents;
   B. Asthma.

IV. Appendices/General Information
   Appendix A: Abbreviation/Acronym Key
   COPD: chronic obstructive pulmonary disease
   FDA: Food and Drug Administration
   GOLD: Global Initiative for Chronic Obstructive Lung Disease
   ICS: inhaled corticosteroid
   LABA: long-acting beta2 adrenergic agonist
   LAMA: long-acting anticholinergic

   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.
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/ Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incredse Ellipta (umeclidinium)</td>
<td>1 inhalation (62.5 mcg) QD</td>
<td>62.5 mcg/day</td>
</tr>
<tr>
<td>Spiriva Handihaler/ Respimat (tiotropium)</td>
<td>Handihaler: 2 inhalations (total 18 mcg) QD</td>
<td>Handihaler: 18 mcg/day</td>
</tr>
<tr>
<td></td>
<td>Respimat: 2 inhalations (total 5 mcg) QD</td>
<td>Respimat: 5 mcg/day</td>
</tr>
<tr>
<td>budesonide/ formoterol (Symbicort)</td>
<td>2 inhalations of 160/4.5 mcg BID</td>
<td>2 inhalations of 160/4.5 mcg BID</td>
</tr>
<tr>
<td>Serevent (salmeterol)</td>
<td>1 inhalation (50 mcg) BID</td>
<td>100 mcg/day</td>
</tr>
<tr>
<td>Stiverdi Respimat (olodaterol)</td>
<td>2 inhalations (total 5 mcg) QD</td>
<td>5 mcg/day</td>
</tr>
<tr>
<td>Breo Ellipta (fluticasone/vilanterol)</td>
<td>1 inhalation (100/25 mcg) QD</td>
<td>100/25 mcg/day</td>
</tr>
<tr>
<td>fluticasone/salmeterol (Advair Diskus, Wixela Inhub)</td>
<td>1 inhalation (250/50 mcg) BID</td>
<td>500/100 mcg/day</td>
</tr>
</tbody>
</table>

*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**
- Contraindications: hypersensitivity; use of a LABA, including formoterol fumarate, one of the active ingredients in Duaklir Pressair, without an ICS in patients with asthma
- Boxed warning(s): none reported

**Appendix D: General Information**
- Per the 2020 GOLD COPD guidelines, combination therapy (LAMA + LABA, ICS + LABA, or ICS + LAMA + LABA) is recommended for Group D patients (i.e., those who are very symptomatic and are at high risk of exacerbation). Selection of which combination to use depends on the individual patient:
  - For those with more severe symptoms, LAMA + LABA may be used.
  - For those with a history of asthma or blood eosinophil counts at least 300 cells/uL, LABA + ICS may be used.
  - For those who are inadequately controlled by dual therapy, triple therapy with ICS + LAMA + LABA may be used.

**V. Dosage and Administration**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD</td>
<td>One inhalation by mouth BID</td>
<td>2 inhalations/day</td>
</tr>
</tbody>
</table>

**VI. Product Availability**
- Inhalation powder: 30 and 60 metered dose dry powder inhaler metering 400 mcg aclidinium bromide and 12 mcg formoterol fumarate per actuation
VII. References

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created per SDC and prior clinical guidance (adapted from HIM.PA.06 which is being retired); revised examples of formulary products appropriate for redirection by removing Tudorza Pressair, adding Advair® HFA, and clarifying generic Advair Diskus/Wixela Inhum.</td>
<td>01.21.20</td>
<td>02.20</td>
</tr>
<tr>
<td>3Q 2020 annual review: no significant changes; added Striverdi Respimat a preferred LABA option per Commercial and core Ambetter formularies; removed Advair HFA as a preferred ICS/LABA option as it is not used for COPD (asthma only); specified that generic (as opposed to brand) Symbicort is preferred per SDC; references reviewed and updated.</td>
<td>04.15.20</td>
<td>08.20</td>
</tr>
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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.

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