

Clinical Policy: Naloxone (Evzio)

Reference Number: CP.PMN.139

Effective Date: 11.16.16

Last Review Date: 08.21

Line of Business: Commercial, Medicaid

[Coding Implications](#)
[Revision Log](#)

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

Description

Naloxone (Evzio[®]) is an opioid antagonist.

FDA Approved Indication(s)

Evzio is indicated for the emergency treatment of known or suspected opioid overdose, as manifested by respiratory and/or central nervous system depression in adults and pediatric patients.

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

I. Initial Approval Criteria

A. Opioid Overdose (must meet all):

1. Member may have access to opioids;
2. Member must use naloxone (Narcan[®]) nasal spray and naloxone solution for injection, unless contraindicated or clinically significant adverse effects are experienced;
3. Requested quantity does not exceed two boxes (4 autoinjectors) per prescription.

Approval duration:

Medicaid – 6 months

Legacy WellCare – 12 months

Commercial – 6 months or to member's renewal period, whichever is longer

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 CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Opioid Overdose (must meet all):

1. Previously received medication via Centene benefit or member has previously met initial approval criteria;
2. If request is for a dose increase, the requested quantity does not exceed two boxes (4 autoinjectors) per prescription.

Approval duration:

Medicaid/Legacy WellCare – 12 months

Commercial – 6 months or to member's renewal period, whichever is longer

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 6 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 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 – CP.CPA.09 for Commercial and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviations/Acronym Key

FDA: Food and Drug Administration

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
Narcan [®] nasal spray (naloxone)	4 mg intranasally as a single spray in one nostril. Repeat as needed every 2 to 3 minutes with a new nasal spray in alternate nostrils. Additional doses may be administered every 2 to 3 minutes until emergency medical assistance arrives	Not applicable
naloxone 0.4 mg/mL solution	Adults: 0.4 to 2 mg IV, repeat every 2 to 3 minutes as needed; if no response after 10 mg, reconsider diagnosis of opioid toxicity; may administer IM or SC if IV route is unavailable Pediatrics: 0.01 mg/kg IV followed by 0.1 mg/kg IV if desired clinical response has not been achieved; divided doses may be given via IM or SC route if IV route is not available	Not applicable

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): hypersensitivity to naloxone hydrochloride
- Boxed warning(s): none reported

Appendix D: General Information

- Evzio is intended for immediate administration as emergency therapy in settings where opioids may be present.
- Evzio is not a substitute for emergency medical care. If the desired response is not obtained after 2 or 3 minutes, another Evzio dose may be administered. If there is still no response and additional doses are available, additional Evzio doses may be administered every 2 to 3 minutes until emergency medical assistance arrives. If no response is observed after 10 mg of naloxone hydrochloride have been administered, the diagnosis of narcotic-induced or partial narcotic induced toxicity should be questioned. Additional supportive and/or resuscitative measures may be helpful while awaiting emergency medical assistance.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Known or suspected opioid overdose	0.4 mg or 2 mg IM or SC. Repeat doses of Evzio may be required depending upon the amount, type, and route of administration of the opioid being antagonized. If there is still no response and additional doses are available, additional Evzio doses may be administered every 2 to 3 minutes until emergency medical assistance arrives.	Not applicable

VI. Product Availability

Auto-injector containing a single dose of naloxone 0.4 mg/0.4 mL or 2 mg/0.4 mL; each carton contains two auto-injectors

VII. References

1. Evzio Prescribing Information. Richmond, VA: Kaleo Inc.; October 2016. Available at www.evzio.com. Accessed May 12, 2021.
2. FDA’s Summary Review for Regulatory Action for Evzio accessed at: http://www.accessdata.fda.gov/drugsatfda_docs/nda/2014/205787Orig1s000SumR.pdf.
3. Micromedex[®] Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed May 12, 2021.

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
J3490, C9399	EVZIO 2MG/0.4ML Solution Auto-injector

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template; minor changes to verbiage and grammar. References updated.	1.11.17	08.17
3Q 2018 annual review: combined policy for Medicaid (new) and 4ommercial; removed Narcan from the policy as Narcan is formulary without PA for both Medicaid and Commercial; references reviewed and updated.	05.21.18	08.18
3Q 2019 annual review: no significant changes; references reviewed and updated.	05.20.19	08.19
3Q 2020 annual review: no significant changes; references reviewed and updated.	05.11.20	08.20
3Q 2021 annual review: no significant changes; added Legacy WCG LOB with initial auth duration of 12 months, retired WCG.CP.PMN.139 Naloxone (Evzio) 12.10.20; updated “Medical justification” language to “Member must use”; added HCPCS code; references reviewed and updated.	05.12.21	08.21

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

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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.

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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.

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