

Clinical Policy: Naproxen Oral Suspension (Naprosyn)

Reference Number: HIM.PA.130

Effective Date: 12.01.17

Last Review Date: 11.20

Line of Business: HIM

[Revision Log](#)

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

Description

Naproxen oral suspension (Naprosyn[®]) is a non-steroidal anti-inflammatory drug (NSAID).

FDA Approved Indication(s)

Naprosyn suspension is indicated:

- For the relief of the signs and symptoms of rheumatoid arthritis
- For the relief of the signs and symptoms of osteoarthritis
- For the relief of the signs and symptoms of ankylosing spondylitis
- For the relief of the signs and symptoms of polyarticular juvenile idiopathic arthritis
- For the relief of the signs and symptoms of tendonitis
- For the relief of the signs and symptoms of bursitis
- For the relief of the signs and symptoms of acute gout
- For the management of pain
- For the management of primary dysmenorrhea

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 Naprosyn oral suspension is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Request for Naprosyn Oral Suspension (must meet all):

1. Age \geq 2 years;
2. Documentation supports inability to use generic naproxen oral tablets;
3. Dose does not exceed any of the following (a or b):
 - a. Adults: 1,500 mg per day (60 mL per day);
 - b. Pediatrics: 15 mg/kg per day.

Approval duration: 12 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.

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II. Continued Therapy

A. All Indications in Section I (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. If request is for a dose increase, new dose does not exceed any of the following (a or b):
 - a. Adults: 1,500 mg per day (60 mL per day);
 - b. Pediatrics: 15 mg/kg 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.

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 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CABG: coronary artery bypass graft
 FDA: Food and Drug Administration
 NSAID: non-steroidal anti-inflammatory drug

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 |
|-----------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------|
| naproxen oral tablets | <u>Ankylosing Spondylitis, Osteoarthritis, Rheumatoid Arthritis</u> 250-500 mg PO BID | 1,500 mg/day |
| | <u>Bursitis, Pain, Primary Dysmenorrhea, Acute Tendonitis</u> 500 mg PO followed by 250 mg Q6-8 hrs | |
| | <u>Acute Gout</u> | |

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| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|-----------|------------------------------------------------------------------------------|-----------------------------|
| | 750 mg PO followed by 250 mg PO Q8 hrs until attack has subsided | |
| | <u>Juvenile Idiopathic Arthritis</u> 10 mg/kg/day PO in two divided doses | |

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 naproxen or any components of the drug product; history of asthma, urticarial, or other allergic-type reactions after taking aspirin or other NSAIDs; in the setting of coronary artery bypass graft (CABG) surgery
- Boxed warning(s): cardiovascular thrombotic events; gastrointestinal bleeding, ulceration, and perforation

V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|--------------------------------------------------------------|------------------------------------------------------------------|--------------|
| Ankylosing spondylitis, osteoarthritis, rheumatoid arthritis | 250-500 mg PO BID | 1,500 mg/day |
| Bursitis, pain, primary dysmenorrhea, acute tendonitis | 500 mg PO followed by 250 mg Q6-8 hrs as required | 1,250 mg/day |
| Acute gout | 750 mg PO followed by 250 mg PO Q8 hrs until attack has subsided | 1,250 mg/day |
| Polyarticular juvenile idiopathic arthritis | 10 mg/kg/day PO in two divided doses | 15 mg/kg/day |

VI. Product Availability

Oral suspension: 125 mg/5 mL

VII. References

1. Naprosyn Prescribing Information. Athens, GA: Athena Bioscience, LLC; July 2019. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/018965s026lbl.pdf. Accessed August 21, 2020.
2. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed August 21, 2020.

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|-----------------------------------|----------|-------------------|
| Policy created | 09.01.17 | 11.17 |

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| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|-------------------|
| 4Q 2018 annual review: no significant changes; references reviewed and updated. | 07.16.18 | 11.18 |
| 4Q 2019 annual review: no significant changes; clarified that the required naproxen oral tablet trial is for generic naproxen tablets; differentiated the maximum allowed adult dose from the maximum allowed pediatric dose, to reflect dosing outlined in the PI; references reviewed and updated. | 08.25.19 | 11.19 |
| 4Q 2020 annual review: no significant changes; references reviewed and updated. | 08.21.20 | 11.20 |

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

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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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