Clinical Policy: Propranolol HCl Oral Solution (Hemangeol)

Reference Number: CP.PMN.58
Effective Date: 05.01.14
Last Review Date: 05.20
Line of Business: HIM, Medicaid

Revision Log

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

Description

Propranolol HCl oral solution (Hemangeol®) is a beta-adrenergic blocker.

FDA Approved Indication(s)

Hemangeol oral solution is indicated for the treatment of proliferating infantile hemangioma requiring systemic therapy.

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

I. Initial Approval Criteria

A. Proliferating Infantile Hemangioma (must meet all)**:**

1. Diagnosis of proliferating infantile hemangioma;
2. Age ≥ 5 weeks;
3. Weight ≥ 2 kg.

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. Proliferating Infantile Hemangioma (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. Member meets one of the following (a or b):
   a. Member has not received ≥ 12 months of consecutive therapy;
   b. Documentation supports recurrence of hemangioma.

Approval duration: 6 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
HCl: hydrochloride
IH: infantile hemangioma

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed warnings
- Contraindication(s): premature infants with corrected age of less than 5 weeks, infants weighing less than 2 kg, asthma or history of bronchospasm, heart rate less than 80 beats/min, blood pressure less than 50/30mmHg, pheochromocytoma, hypersensitivity to propranolol or its excipients
- Boxed warning(s): none reported

Appendix D: Management of IH
- IHs are the most common tumors of childhood. While they often involute after proliferation, there are some that rapidly develop complications, resulting in pain, functional impairment, or permanent disfiguration. For such complicated cases of IH, propranolol is a first-line medical therapy.
- Although the most dramatic improvement using propranolol for IH occurs within 3 to 4 months of initiation of therapy, the optimal treatment duration has not been established:
  - The FDA recommends the maintenance dose be maintained for 6 months. This is likely based on the clinical trial for approval which evaluated patients after 6 months of treatment.
  - The American Academy of Pediatrics indicates that many continue therapy until patients reach an age when IH would normally begin to regress without treatment-often until at least 8 to 12 months of age, which, in most studies, equated to 3 to 12 months of therapy.

- While Hemangeol is effective, rebound growth has been observed in 6% to 25% of children. In the Hemangeol clinical trial, 10% of patients deemed successes after 6-months of therapy later required re-treatment for recurrence.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Proliferating infantile hemangioma	0.15 mL/kg (0.6 mg/kg) PO twice daily, increase to 0.3 mL/kg (1.1 mg/kg) twice daily after 1 week, then to a maintenance dose of 0.4 mL/kg (1.7 mg/kg) twice daily	Depends on weight

VI. Product Availability

Oral solution: 4.28 mg/mL

VII. References

1. Hemangeol Prescribing Information. Parsippany, NJ: Pierre Fabre Pharmaceuticals, Inc; January 2015. Available at: http://www.hemangeol.com. Accessed February 5, 2020.
2. Darrow DH, Greene AK, Mancini AJ, et al. American Academy of Pediatrics clinical report (guidance for the clinician in rendering pediatric care): diagnosis and management of infantile hemangioma. Pediatrics. 2015; 136(4): e1060-e1104.
3. Krowchuk DP, Frieden IJ, Mancini AJ, et al: Clinical practice guideline for the management of infantile hemangiomas. Pediatrics 2019; 143(1):e20183475.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Updated template and references. Added requirement for previous fulfilment of Centene coverage criteria for continued approval. Changed weight requirement from ≤ 2 kg to ≥ 2 kg in accordance with FDA labeling. Added workflow document.	05.16	08.16
Removed upper age limit as Hemangeol has demonstrated efficacy in older children per literature review; Removed hard stop at 6 months of total treatment and all criteria referencing said hard stop; Added criteria to allow continued therapy for recurrence of hemangioma or for those requiring up to 12 consecutive months of treatment per AAP clinical report; Converted to new template; Updated references	03.17	05.17
2Q 2018 annual review: no significant changes - policies combined for HIM and Medicaid; references reviewed and updated.	02.06.18	05.18
2Q 2019 annual review: no significant changes; added clinical practice guidelines for management of infantile hemangiomas to references; added contraindications; references reviewed and updated.	02.07.18	05.19
2Q20 annual review: no significant changes; references reviewed and updated.	02.05.20	05.20

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 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.

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.