Clinical Policy: Levalbuterol (Xopenex HFA/Inhalation Solution)
Reference Number: CP.PMN.07
Effective Date: 09.01.06
Last Review Date: 02.20
Line of Business: HIM, Medicaid

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

Description
Levalbuterol (Xopenex®) is a beta$_2$-adrenergic agonist.

FDA Approved Indication(s)
Xopenex is indicated for the treatment or prevention of bronchospasm in adults, adolescents, and children (HFA: 4 years of age and older; inhalation solution: 6 years of age and older) with reversible obstructive airway disease.

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 Xopenex is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Request for Xopenex HFA/Inhalation Solution (must meet all):
      1. Member meets one of the following (a or b):
         a. Presence of cardiac disease;
         b. Member experienced clinically significant adverse effects from albuterol use within the last 90 days;
      2. Member does NOT have history of allergy or hypersensitivity to albuterol or levalbuterol;
      3. Request does not exceed (a or b):
         a. Xopenex HFA: 2 inhalers per 30 days;
         b. Xopenex inhalation solution: 4 vials per day (12 mL per day).

   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. Request for Xopenex HFA/Inhalation Solution (must meet all):


Revise Log
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. Albuterol has not been used within the past 3 months as evidenced by pharmacy claims history;
4. If request is for a dose increase, request does not exceed (a or b):
   a. Xopenex HFA: 2 inhalers per 30 days;
   b. Xopenex inhalation solution: 4 vials per day (12 mL 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 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
   MDI: metered-dose inhaler

   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>albuterol (ProAir HFA®, Proventil HFA®, Ventolin HFA®)</td>
<td>Metered-dose inhaler [MDI] (e.g., ProAir HFA): 2 puffs every 4 to 6 hours as needed</td>
<td>MDI: 12 puffs/day</td>
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<tr>
<td></td>
<td>Nebulization solution: 2.5 mg via oral inhalation every 6 to 8 hours as needed</td>
<td>Nebulization solution: 4 doses/day or 10 mg/day</td>
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<td></td>
<td></td>
<td>Higher maximum dosages for inhalation products have been recommended in National Asthma Education and Prevention Program guidelines</td>
</tr>
</tbody>
</table>
Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): history of hypersensitivity to levalbuterol or racemic albuterol (or any other component of Xopenex HFA inhalation aerosol)
- Boxed warning(s): none reported

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment or prevention of bronchospasm</td>
<td>MDI (Xopenex HFA): 2 puffs every 4 to 6 hours as needed; in some patients, 1 puff every 4 hours may be sufficient</td>
<td>MDI: 2 puffs every 4 hours; higher doses may be required acutely during severe exacerbations</td>
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<tr>
<td></td>
<td>Nebulization solution: 0.31 mg to 1.25 mg inhaled via nebulization 3 times per day, given every 6 to 8 hours</td>
<td>Nebulization solution: 1.25 mg/dose 3 times/day</td>
</tr>
</tbody>
</table>

VI. Product Availability

- Inhalation aerosol: 59 mcg of levalbuterol tartrate (equivalent to 45 mcg of levalbuterol free base) per actuation
  - 15 g pressurized canister containing 200 actuations
- Inhalation solution (unit-dose vial for nebulization): 0.31 mg/3 mL, 0.63 mg/3 mL, 1.25 mg/3 mL
- Inhalation solution concentrate: 1.25 mg/0.5 mL

VII. References


<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
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<tr>
<td>No Changes.</td>
<td>02.15</td>
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<tr>
<td>Converted to new template</td>
<td>08.15</td>
<td>08.15</td>
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<tr>
<td>Added requirement for side effect to albuterol use in the last 90 days to criteria for approval</td>
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<tr>
<td>Updated Reference section to reflect current literature search</td>
<td>11.15</td>
<td>02.16</td>
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<tr>
<td>Converted to new integrated template;</td>
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<tr>
<td>Modified QL of HFA from 1 inhaler/30 days to 2 inhalers/30 days (in line with QL for PDL Ventolin HFA, Proair HFA); specified duration of approval for initial and re-auth criteria;</td>
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<td>Re-auth: added requirements related to positive response to therapy and albuterol has not been used within the past 3 months as evidenced by pharmacy claims history;</td>
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<td>Updated references</td>
<td>11.16</td>
<td>02.17</td>
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<td>IQ18 annual review:</td>
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<td></td>
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<tr>
<td>- Policies combined for Centene Medicaid and Marketplace lines of business</td>
<td>10.26.17</td>
<td>02.18</td>
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<td>- No significant changes from previous corporate approved policy</td>
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<tr>
<td>- Medicaid: modified QL of inhalation solution from 3 vials/day to 4 vials (12 mL)/day</td>
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<td>- References reviewed and updated.</td>
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<td>1Q 2019 annual review: no significant change from previously approved policy; references reviewed and updated.</td>
<td>09.25.18</td>
<td>02.19</td>
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<td>09.23.19</td>
<td>02.20</td>
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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.
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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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