Clinical Policy: Sildenafil (Revatio)

Reference Number: MDN.CP.PHAR.197
Effective Date: 04.01.22
Last Review Date: 9.13.22
Line of Business: Meridian IL Medicaid

Coding Implications
Revision Log

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

Description
Sildenafil (Revatio®) is a phosphodiesterase-5 inhibitor.

FDA Approved Indication(s)
Revatio is indicated for the treatment of pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1) in adults to improve exercise ability and delay clinical worsening. The delay in clinical worsening was demonstrated when Revatio was added to background epoprostenol therapy.

Studies establishing effectiveness were short-term (12 to 16 weeks), and included predominately patients with New York Heart Association (NYHA) Functional Class II-III symptoms and idiopathic etiology (71%) or associated with connective tissue disease (25%).

Limitation(s) of use: Adding sildenafil to bosentan therapy does not result in any beneficial effect on exercise capacity.

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

I. Initial Approval Criteria

A. Pulmonary Arterial Hypertension (must meet all)**:**

1. Diagnosis of PAH;
2. Prescribed by or in consultation with a cardiologist or pulmonologist;
3. Failure of a calcium channel blocker (*see Appendix B*), unless member meets one of the following (a or b):
   a. Inadequate response or contraindication to acute vasodilator testing;
   b. Contraindication or clinically significant adverse effects to calcium channel blockers are experienced;
4. Request is for sildenafil 20mg tablet

**Prior authorization may be required for Revatio 10mg/mL oral susp, sildenafil 20mg tablet*

5. If request is for Revatio® 10mg/mL oral susp, member must be unable to ingest a solid dosage form by meeting a, b or c
   a. Documentation why member cannot take solid dosage form (age, g-tube, etc)
   b. Oral-motor difficulties
   c. Dysphagia

   **Prior authorization may be required for Revatio 10mg/mL oral susp, sildenafil 20mg tablet*
6. If request is for brand Revatio® 10mg/12.5mL vial, brand Revatio® 20mg tablet, sildenafil 10mg/12.5mL vial, or sildenafil 10mg/mL oral susp there must be evidence of failure of one of the PDL drugs, used for ≥ 3 consecutive months, unless contraindicated or clinically significant adverse effects are experienced brand
   a. Revatio® 10mg/mL oral susp (unable to ingest a solid dosage form due to i, ii, or iii)
      i. Documentation why member cannot take solid dosage form (age, g-tube, etc)
      ii. Oral-motor difficulties
      iii. Dysphagia
   b. sildenafil 20mg tablet;

**Prior authorization may be required for Revatio 10mg/mL oral susp, sildenafil 20mg tablet*

7. Dose does not exceed 60 mg per day (oral formulations) or 30 mg per day (intravenous formulations) in divided doses.

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): CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Pulmonary Arterial Hypertension (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy;
   **Prior authorization may be required for Revatio 10mg/mL oral susp, sildenafil 20mg tablet*
3. If request is for a dose increase, new dose does not exceed 60 mg per day (oral formulations) or 30 mg per day (intravenous formulations) in divided doses.

   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 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.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.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FC: functional class
FDA: Food and Drug Administration
NYHA: New York Heart Association
PAH: pulmonary arterial hypertension
PH: pulmonary hypertension
WHO: World Health Organization

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
nifedipine (Adalat® CC, Afeditab® CR, Procardia®, Procardia XL®)	60 mg PO QD; may increase to 120 to 240 mg/day	240 mg/day
diltiazem (Dilacor XR®, Dilt-XR®, Cardizem® CD, Cartia XT®, Tiazac®, Taztia XT®, Cardizem® LA, Matzim® LA)	720 to 960 mg PO QD	960 mg/day
amlodipine (Norvasc®)	20 to 30 mg PO QD	30 mg/day

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):
  - Use with organic nitrates or riociguat
  - History of hypersensitivity reaction to sildenafil or any component of the tablet, injection, or oral suspension
- Boxed warning(s): none reported

Appendix D: Pulmonary Hypertension: WHO Classification
- Group 1: PAH (pulmonary arterial hypertension)
- Group 2: PH due to left heart disease
- Group 3: PH due to lung disease and/or hypoxemia
- Group 4: CTEPH (chronic thromboembolic pulmonary hypertension)
- Group 5: PH due to unclear multifactorial mechanisms

Appendix E: Pulmonary Hypertension: WHO/NYHA Functional Classes (FC)

Treatment Approach*	FC	Status at Rest	Tolerance of Physical Activity (PA)	PA Limitations	Heart Failure
Monitoring for progression of PH and treatment of co- existing conditions	I	Comfortable at rest	No limitation	Ordinary PA does not cause undue dyspnea or fatigue, chest pain, or near syncope.	
Advanced treatment of PH with PH-targeted therapy	II	Comfortable at rest	Slight limitation	Ordinary PA causes undue dyspnea or fatigue, chest pain, or near syncope.	

Treatment Approach*	FC	Status at Rest	Tolerance of Physical Activity (PA)	PA Limitations	Heart Failure
- *see Appendix F***	III	Comfortable at rest	Marked limitation	Less than ordinary PA causes undue dyspnea or fatigue, chest pain, or near syncope.	
	IV	Dyspnea or fatigue may be present at rest	Inability to carry out any PA without symptoms	Discomfort is increased by any PA.	Signs of right heart failure

*PH supportive measures may include diuretics, oxygen therapy, anticoagulation, digoxin, exercise, pneumococcal vaccination. **Advanced treatment options also include calcium channel blockers.

Appendix F: Pulmonary Hypertension: Targeted Therapies

Mechanism of Action	Drug Class	Drug Subclass	Drug	Brand/Generic Formulations
Reduction of pulmonary arterial pressure through vasodilation	Prostacyclin* pathway agonist **Member of the prostanoid class of fatty acid derivatives.*	Prostacyclin	Epoprostenol	Veletri (IV) Flolan (IV) Flolan generic (IV)
		Synthetic prostacyclin analog	Treprostinil	Orenitram (oral tablet) Remodulin (IV) Tyvaso (inhalation)
			Iloprost	Ventavis (inhalation)
		Non-prostanoid prostacyclin receptor (IP receptor) agonist	Selexipag	Uptravi (oral tablet)
	Endothelin receptor antagonist (ETRA)	Selective receptor antagonist	Ambrisentan	Letairis (oral tablet)
		Nonselective dual action receptor antagonist	Bosentan	Tracleer (oral tablet)
			Macitentan	Opsumit (oral tablet)
	Nitric oxide-cyclic guanosine monophosphate enhancer	Phosphodiesterase type 5 (PDE5) inhibitor	Sildenafil	Revatio (IV, oral tablet, oral suspension)
			Tadalafil	Adcirca (oral tablet)
		Guanylate cyclase stimulant (sGC)	Riociguat	Adempas (oral tablet)

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PAH	Tablet and oral suspension: 5 mg or 20 mg PO TID, 4-6 hours apart Injection: 2.5 mg or 10 mg TID as an IV bolus	Tablet/oral suspension: 60 mg/day Injection: 30 mg/day

VI. Product Availability

- Tablet: 20 mg
- Oral suspension: 10 mg/mL
- Single-use vial: 10 mg/12.5 mL

VII. References

1. Revatio Prescribing Information. New York, NY: Pfizer Inc.; February 2018. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2018/021845s018lbl.pdf. Accessed November 9, 2021.
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6. Galiè N, Humbert M, Vachiary JL, et al. 2015 ESC/ERS Guidelines for the diagnosis and treatment of Pulmonary Hypertension. *European Heart Journal*. Doi:10.1093/eurheartj/ehv317.
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9. Yaghi S, Novikov A, Trandafirescu T. Clinical update on pulmonary hypertension. *J Investig Med*. 2020; 0:1-7. doi:10.1136/jim-2020-001291.

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	Unclassified drugs
J8499	Prescription drug, oral, non-chemotherapeutic, Not Otherwise Specified

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created, adapted from CP.PHAR.197	04.01.22	04.22
Updated logo; Initial and Continuing approval criteria clarified	9.13.22	

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.