

<b>Clinical Policy Title:</b>	ambrisentan
<b>Policy Number:</b>	RxA.203
<b>Drug(s) Applied:</b>	ambrisentan
<b>Original Policy Date:</b>	02/07/2020
<b>Last Review Date:</b>	12/11/2025
<b>Line of Business Policy Applies to:</b>	All lines of business (except Medicare)

## Criteria

### I. Initial Approval Criteria

#### A. Pulmonary arterial hypertension (PAH) (must meet all):

1. Diagnosis of PAH;
2. Trial and failure of at least one (1) calcium channel blocker, 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;

#### Approval Duration

**All Lines of Business (except Medicare):** 6 months

### II. Continued Therapy Approval

#### A. Pulmonary arterial hypertension (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

#### Approval Duration

**All Lines of Business (except Medicare):** 12 months

## References

1. Taichman D, Ornelas J, Chung L, et al. CHEST guideline and expert panel report: Pharmacologic therapy for pulmonary arterial hypertension in adults. *Chest*. 2014; 146 (2): 449-475. Available at: <https://pubmed.ncbi.nlm.nih.gov/24937180/>. Accessed August 28, 2024.
2. Abman SH, Hansmann G, Archer SL, et al. Pediatric pulmonary hypertension: Guidelines from the American Heart Association and American Thoracic Society. *Circulation*. 2015 Nov 24; 132(21): 2037-99. Available at: <https://pubmed.ncbi.nlm.nih.gov/26534956/>. Accessed August 28, 2024.
3. Kim NH, Delcroix M, Jenkins DP, et al. Chronic thromboembolic pulmonary hypertension. *J Am Coll Cardiol* 2013; 62(25): Suppl D92-99. Available at: <https://pubmed.ncbi.nlm.nih.gov/24355646/>. Accessed August 28, 2024.
4. 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. Available at: <https://pubmed.ncbi.nlm.nih.gov/26320113/>. Accessed August 28, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Policy description table was updated</li> <li>2. Continuation therapy criteria II.A.1. was rephrased to “Member is currently receiving medication that has been authorized by RxAdvance...”</li> <li>3. Initial therapy and continued therapy approval duration for “commercial” was updated from length of benefit to 6 months and 12 months respectively.</li> <li>4. References were updated</li> </ol>	06/15/2020	09/14/2020
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Age criteria was added to Initial approval criteria I.A.3.</li> <li>2. References were reviewed and updated.</li> </ol>	03/04/2021	06/10/2021
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. References were reviewed and updated.</li> </ol>	01/17/2022	04/18/2022
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. References were reviewed and updated.</li> </ol>	02/15/2023	04/13/2023
<p>Policy was reviewed.</p>	10/19/2023	10/19/2023
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Added generic ambrisentan to Drug(s) Applied.</li> <li>2. Removed prescriber restrictions.</li> <li>3. Removed age restrictions.</li> <li>4. Removed dose restrictions.</li> <li>5. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days.</li> <li>6. Removed reauthorization requirement for positive response to therapy.</li> <li>7. Updated approval duration verbiage.</li> <li>8. References were reviewed and updated.</li> </ol>	08/28/2024	09/13/2024
<p>Policy was reviewed:</p> <ol style="list-style-type: none"> <li>1. Removed Letairis from drug applied section.</li> </ol>	12/05/2024	N/A
<p>Policy reviewed.</p>	12/11/2025	12/11/2025