Clinical Policy Title:	selexipag
Policy Number:	RxA.290
Drug(s) Applied:	Uptravi®
Original Policy Date:	02/07/2020
Last Review Date:	10/19/2023
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

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. Age ≥ 18 years;
4. Trial and failure of a 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;
5. Request meets one of the following (a or b):
   a. Tablet: Dose does not exceed 3,200 mcg per day (if request is for titration, provider must submit a titration plan).
   b. Injection: Member is temporarily unable to take oral therapy and dose does not exceed 3,600 mcg per day (if request is for titration, provider must submit a titration plan).

Approval Duration
Commercial: 6 months
Medicaid: 6 months

II. Continued Therapy Approval

A. Pulmonary Arterial Hypertension (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria listed in this policy;
2. Member is responding positively to therapy;
3. Request meets one of the following (a or b):
   a. Tablet: Dose does not exceed 3,200 mcg per day (if request is for titration, provider must submit a titration plan).
   b. Injection: Member is temporarily unable to take oral therapy and dose does not exceed 3,600 mcg per day (if request is for titration, provider must submit a titration plan).

Approval Duration
Commercial: 12 months
Medicaid: 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://www.ncbi.nlm.nih.gov/pmc/articles/PMC4137591/. Accessed January 09, 2023.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020
Policy was reviewed: 1. Policy title table was updated. 2. Continued therapy criteria II.A.1 was rephrased to “Currently receiving medication that has been authorized by RxAdvance…”. 3. Approval duration was updated to include months in initial approval as well as in clinical therapy criteria. 4. QD was updated with once daily in document. 5. All brand drugs were updated to have “®” for consistency. 6. References were updated.	07/23/2020	09/14/2020
Policy was reviewed: 1. Initial approval criteria I.A.3 was added to consider patient age. 2. Initial approval criteria I.A.4a was updated to change term “vasodilator” to “vasoreactivity” for accuracy. 3. Continued therapy criteria II.A.1 was rephrased to “Member is currently receiving medication…”. 4. References were updated.	04/02/2021	06/10/2021
Policy was reviewed: 1. Continued Therapy Approval Criteria II.A.1 was rephrased to "Member is currently receiving medication that has been authorized by RxAdvance...". 2. References were reviewed and updated.	01/27/2022	04/18/2022
Policy was reviewed: 1. References were reviewed and updated.	01/09/2023	04/13/2023
Policy was reviewed.	10/19/2023	10/19/2023