PURPOSE OF THE POLICY

To establish prior authorization criteria for Epoprostenol.

STATEMENT OF THE POLICY

Health Alliance Medical Plans will approve the use of Epoprostenol when the following criteria have been met.

CRITERIA

1. Coverage Criteria

1.1 All FDA approved indications not otherwise excluded from Medicare Part D
1.2 For the treatment of pulmonary arterial hypertension (PAH) in patients with NYHA Class II, III or IV symptoms
1.3 Documentation of previous medications used. Patient must have tried and failed oral calcium channel blockers and conventional therapies, including oral anticoagulants, diuretics, supplemental oxygen, and/or digoxin, unless contraindicated
1.4 Documentation of positive acute vasoreactivity test result unless contraindicated (e.g. unstable patients or those with severe right heart failure)
1.5 Veletri requires a documented trial of generic epoprostenol prior to coverage of brand.
1.6 Prescribed by a pulmonologist or cardiologist
1.7 Coverage duration is 1 year at a time
1.8 B vs. D decisions

2. Exclusion Criteria

2.1 Patients with hypersensitivity to prostacyclin analogs, high risk of hemorrhage (e.g. active peptic ulcers, trauma, intracranial hemorrhage), severe coronary heart disease, unstable angina, MI within the last 6 months, decompensated cardiac failure not under close medical supervision, severe arrhythmias, cerebrovascular events within the last 3 months, or pulmonary hypertension caused by venous occlusive disease
2.2 Pregnancy

REFERENCES