Clinical Policy: Levalbuterol (Xopenex HFA/Inhalation Solution)
Reference Number: CP.PMN.07
Effective Date: 09.01.06
Last Review Date: 02.18
Line of Business: Health Insurance Marketplace, Medicaid

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

Description
Levalbuterol (Xopenex®) is a beta2-adrenergic agonist.

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

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) 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. 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):
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. 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>
</tr>
<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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<tr>
<td></td>
<td>Higher maximum dosages for inhalation products have been recommended in National Asthma Education and Prevention Program guidelines</td>
<td></td>
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CLINICAL POLICY
Levalbuterol

<table>
<thead>
<tr>
<th>Drug Name</th>
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<td></td>
<td>for acute exacerbations of asthma.</td>
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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.

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</td>
<td>MDI: 2 puffs every 4 hours; higher doses may be required acutely during severe exacerbations</td>
</tr>
<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
  - 8.4 g pressurized canister containing 80 actuations
- Inhalation solution (unit-dose vial for nebulization): 0.31 mg/3 mL, 0.63 mg/3 mL and 1.25 mg/3 mL
- Inhalation solution concentrate: 1.25 mg/0.5 mL

VII. References
## 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.

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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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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