

## Clinical Policy: Iloprost (Ventavis)

Reference Number: CP.PHAR.193

Effective Date: 03/16

Last Review Date: 03/17

[Coding Implications](#)  
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for iloprost (Ventavis®).

### Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that Ventavis is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Pulmonary Hypertension (must meet all):

1. Prescribed by or in consultation with a cardiologist or pulmonologist experienced in the diagnosis and treatment of pulmonary hypertension (PH);
2. Diagnosis of PH confirmed by right heart catheterization and classified as (a and b):
  - a. WHO Group 1: PAH (pulmonary arterial hypertension; Appendix B) and (i or ii):
    - i. Inadequate response or contraindication to acute vasodilator testing;
    - ii. Trial and failure of, or contraindication to, at least one calcium channel blocker;
  - b. WHO/NYHA Functional Class II, III or IV (Appendix C);
3. Prescribed dose of Ventavis does not exceed 45 mcg daily.

**Approval duration: 6 months**

**B. Other diagnoses/indications:** Refer to CP.PHAR.57 - Global Biopharm Policy.

#### II. Continued Approval

##### A. Pulmonary 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;
3. Prescribed dose of Ventavis does not exceed 45 mcg daily.

**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; or
2. Refer to CP.PHAR.57 - Global Biopharm Policy.

**Background**

*Description/Mechanism of Action:*

Ventavis (iloprost) Inhalation Solution is a clear, colorless, sterile solution containing iloprost formulated for inhalation via the I-neb® AAD® (Adaptive Aerosol Delivery) System. Iloprost is a synthetic analog of prostacyclin PGI<sub>2</sub>. Iloprost dilates systemic and pulmonary arterial vascular beds. It also affects platelet aggregation but the relevance of this effect to the treatment of pulmonary hypertension is unknown.

*Formulations:*

Solution for inhalation:

Ventavis: 10 mcg/mL (1 mL), 20 mcg/mL (1 mL)

*FDA Approved Indications:*

Ventavis (iloprost) is a synthetic analog of prostacyclin/inhalation solution indicated for:

- Treatment of PAH (WHO Group 1) to improve a composite endpoint consisting of exercise tolerance, symptoms (NYHA Class), and lack of deterioration.
  - Studies establishing effectiveness included predominately patients with NYHA Functional Class III-IV symptoms and etiologies of idiopathic or heritable PAH or PAH associated with connective tissue diseases.

**Appendices**

**Appendix A: Abbreviation Key**

- FC: functional classification
- NYHA: New York Heart Association
- PAH: pulmonary arterial hypertension
- PH: pulmonary hypertension
- WHO: World Health Organization

**Appendix B: 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 C: 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 - see Appendix D**     | II  | Comfortable at rest | Slight limitation                   | Ordinary PA causes undue dyspnea or fatigue, chest pain, or near syncope.         |               |
|  | III | Comfortable at rest | Marked limitation                   | Less than ordinary PA causes undue dyspnea or                                     |               |

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| Treatment Approach* | FC | Status at Rest                            | Tolerance of Physical Activity (PA)            | PA Limitations                        | Heart Failure                |
|---------------------|----|---|--|---------------------------------------|------------------------------|
|                     |    |   |  | 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 D: 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<br><br><i>*Member of the prostanoid class of fatty acid derivatives.</i> | Prostacyclin   | Epoprostenol           | Veletri (IV)<br>Flolan (IV)<br>Flolan generic (IV)                |
|   |  | Synthetic prostacyclin analog                              | Treprostinil           | Orenitram (oral tablet)<br>Remodulin (IV)<br>Tyvasco (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   |  | Opsummit (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)   |

**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  |
|-------------|--|
| Q4074       | Iloprost, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose form, up to 20 mcg |

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| Reviews, Revisions, and Approvals   | Date  | Approval Date |
|---|-------|---------------|
| Policy split from CP.PHAR.33.PAH and converted to new template. Criteria: added specialist requirement; removed echocardiogram as an option for confirming a PH diagnosis; removed hard stop after 3 months of therapy. Appendices removed: 1) examples of calcium channel blocker contraindications; 2) nitrate therapy examples; 3) PAH definition.   | 02/16 | 03/16         |
| FC II is added to the prostanoid class of PH drugs. Safety criteria were removed unless they 1) represent contraindications or black box warnings not covered by a REMS program, and 2) provide specific lab/imaging parameters that must be met prior to initiation of therapy. An efficacy statement is added to the continuation criteria. Initial and continuation durations increased to 6 and 12 months respectively. Appendices covering PH group, functional class and therapy reorganized. | 02/17 | 03/17         |

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#### **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.

## CLINICAL POLICY

### Iloprost

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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.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs and Medicare Coverage articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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