

**Clinical Policy: Tadalafil (Adcirca, Alyq, Tadliq)**

Reference Number: CP.PHAR.198

Effective Date: 03.16

Last Review Date: 02.25

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

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

**Description**

Tadalafil (Adcirca<sup>®</sup>, Alyq<sup>®</sup>, Tadliq<sup>®</sup>) is a phosphodiesterase-5 inhibitor.

**FDA Approved Indication(s)**

Adcirca, Alyq, and Tadliq are indicated for the treatment of pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1) to improve exercise ability.

Studies establishing effectiveness included predominately patients with New York Heart Association (NYHA) Functional Class II-III symptoms and etiologies of idiopathic or heritable PAH (61%) or PAH associated with connective tissue diseases (23%).

**Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that tadalafil, Adcirca, Alyq, and Tadliq are **medically necessary** when the following criteria are met:

**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. Failure of a calcium channel blocker (*see Appendix B*), 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;
4. If request is for brand Adcirca, Alyq, or Tadliq, member must use generic tadalafil, unless contraindicated, clinically significant adverse effects are experienced, or for Tadliq requests member is unable to swallow tablets;
5. Dose does not exceed one of the following (a or b):
  - a. Adcirca, Alyq (i and ii):
    - i. 40 mg per day;
    - ii. 2 tablets per day;
  - b. Tadliq (i and ii):
    - i. 2 bottles per month;
    - ii. 300 mL per month.

**Approval duration:**

**Medicaid/HIM** – 6 months

**Commercial** – 12 months or duration of request, whichever is less

**B. Other diagnoses/indications** (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Pulmonary Arterial Hypertension** (must meet all):

1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. If request is for brand Adcirca, Alyq or Tadliq, member must use generic tadalafil, unless contraindicated, clinically significant adverse effects are experienced, or for Tadliq requests member is unable to swallow tablets;
4. If request is for a dose increase, new dose does not exceed one of the following (a or b):
  - a. Adcirca, Alyq (i and ii):
    - i. 40 mg per day;
    - ii. 2 tablets per day;
  - b. Tadliq (i and ii):
    - i. 2 bottles per month;
    - ii. 300 mL per month.

**Approval duration:**

**Medicaid/HIM** – 12 months

**Commercial** – 12 months or duration of request, whichever is less

**B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 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 – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

CTEPH: chronic thromboembolic pulmonary hypertension	PA: physical activity
FC: functional class	PAH: pulmonary arterial hypertension
FDA: Food and Drug Administration	PH: pulmonary hypertension
NYHA: New York Heart Association	WHO: World Health Organization

*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 and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
nifedipine (Adalat <sup>®</sup> CC, Procardia XL <sup>®</sup> ) <sup>†</sup>	30 mg PO QD; may increase to 60 to 120 mg BID	240 mg/day
diltiazem (Dilt-XR <sup>®</sup> , Cardizem <sup>®</sup> CD, Cartia XT <sup>®</sup> , Tiazac <sup>®</sup> , Cardizem <sup>®</sup> LA, Matzim <sup>®</sup> LA) <sup>†</sup>	60 mg PO BID; may increase to 120 to 360 mg BID	720 mg/day
amlodipine (Norvasc <sup>®</sup> ) <sup>†</sup>	5 mg PO QD; may increase to 15 to 30 mg/day	30 mg/day

Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.

†Off-label

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): concomitant organic nitrates; concomitant guanylate cyclase stimulators; hypersensitivity reactions
- Boxed warning(s): none reported

*Appendix D: Pulmonary Hypertension: WHO Classification*

- Group 1: PAH
- Group 2: PH due to left heart disease
- Group 3: PH due to lung disease and/or hypoxemia
- Group 4: CTEPH
- Group 5: PH due to unclear multifactorial mechanisms

*Appendix E: 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 F**	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 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 F: Pulmonary Hypertension: Targeted Therapies*

Mechanism of Action	Drug Class	Drug Subclass	Drug	Brand/Generic Formulations
		Prostacyclin	Epoprostenol	Veletri (IV)

Mechanism of Action	Drug Class	Drug Subclass	Drug	Brand/Generic Formulations	
Reduction of pulmonary arterial pressure through vasodilation	Prostacyclin* pathway agonist			Flolan (IV) Flolan generic (IV)	
	<i>*Member of the prostanoid class of fatty acid derivatives.</i>	Synthetic prostacyclin analog	Treprostinil	Orenitram (oral tablet) Remodulin (IV) Tyvaso (inhalation)	
			Iloprost	Ventavis (inhalation)	
	Endothelin receptor antagonist (ETRA)	Non-prostanoid prostacyclin receptor (IP receptor) agonist	Selexipag	Uptravi (oral tablet)	
			Selective receptor antagonist	Ambrisentan	Letairis (oral tablet)
				Nonselective dual action receptor antagonist	Bosentan
	Nitric oxide-cyclic guanosine monophosphate enhancer	Phosphodiesterase type 5 (PDE5) inhibitor	Macitentan		Opsumit (oral tablet)
			Sildenafil	Revatio (IV, oral tablet, oral suspension)	
				Tadalafil	Adcirca, Alyq (oral tablet) Tadliq (oral suspension)
		Guanylate cyclase stimulant (sGC)	Riociguat	Adempas (oral tablet)	

#### V. Dosage and Administration

Drug Name	Dosing Regimen	Maximum Dose
Adcirca, Alyq	40 mg PO QD	40 mg/day
Tadliq	40 mg (10 mL) PO QD	40 mg/day

#### VI. Product Availability

Drug Name	Availability
Adcirca, Alyq	Tablet: 20 mg
Tadliq	Oral suspension: 20 mg/5 mL in 150 mL bottle

**VII. References**

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Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	10.12.20	02.21

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 no significant changes; for brand Adecirca or Alyq requests, added redirection to generic tadalafil; references reviewed and updated.	11.09.21	02.22
RT4: newly approved oral suspension formulation Tadliq added to policy. Template changes applied to other diagnoses/indications and continued therapy section.	08.22.22	
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less.	08.23.22	11.22
1Q 2023 annual review: no significant changes; references reviewed and updated.	11.15.22	02.23
1Q 2024 annual review: no significant changes; removed commercially unavailable branded products from Appendix B; references reviewed and updated.	10.03.23	02.24
1Q 2025 annual review: in Policy/Criteria, clarified criteria also applies to brand Adecirca, Alyq, and Tadliq; in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens; clarified drugs used for off-label indications; references reviewed and updated.	11.07.24	02.25

**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.

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