

Pulmonary Hypertension Agents, Oral/Inhaled

Goals:

- Restrict use to appropriate patients with World Health Organization (WHO) Functional Class II-IV symptoms and WHO pulmonary classifications with demonstrated clinical benefit in clinical trials (e.g., pulmonary arterial hypertension (PAH), chronic thromboembolic pulmonary hypertension, or interstitial lung disease).
- Restrict use to conditions covered by the Oregon Health Plan (OHP). Note: erectile dysfunction is not covered by the OHP.

Length of Authorization:

- Up to 12 months

Requires PA:

- Non-preferred drugs (pharmacy and provider administered claims)

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Is the drug being prescribed by, or in consultation with, a pulmonologist or cardiologist?	Yes: Go to #3	No: Pass to RPh. Deny; medical appropriateness.
3. Is the request for riociguat (Adempas [®]) or ambrisentan (Letairis [®])?	Yes: Go to #4	No: Go to #5
4. Is there documentation that the patient has a medical history of PAH associated with idiopathic interstitial pneumonias or idiopathic pulmonary fibrosis?	Yes: Pass to RPh. Deny; medical appropriateness.	No: Go to #5
5. Is the patient classified as having World Health Organization (WHO) Functional Class II-IV symptoms?	Yes: Go to #6	No: Pass to RPh. Deny; medical appropriateness.
6. Is there a diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1; ICD10 I27.0)?	Yes: Go to #7	No: Go to #8
7. Will the prescriber consider a change to a preferred product? <u>Note:</u> preferred products do not require PA.	Yes: Inform prescriber of preferred alternatives in class.	No: Approve for 12 months

Approval Criteria

<p>8. Is the request for riociguat in a patient with a diagnosis of chronic thromboembolic pulmonary hypertension (WHO Group 4; ICD10 I27.24)?</p>	<p>Yes: Approve for 12 months</p>	<p>No: Go to #9</p>
<p>9. Is the request for nebulized treprostinil (Tyvaso®) in a patient with WHO Group 3 pulmonary hypertension (ICD10 I27.23) and a diagnosis of interstitial lung disease (J84.0-J84.9)?</p> <p>Note: treprostinil is not approved in patients with pulmonary hypertension due to chronic obstructive pulmonary disease and may increase risk of exacerbations.</p>	<p>Yes: Approve for 12 months</p>	<p>No: Go to #10</p>
<p>10. Is the request for treatment of erectile dysfunction, sexual dysfunction, or infertility?</p>	<p>Yes: Pass to RPh; Deny; not covered by OHP.</p>	<p>No: Go to #11</p>
<p>11. RPh Only: For other indications and other types of pulmonary hypertension, prescriber must provide supporting literature for use.</p>	<p>Yes: Approve for length of treatment.</p>	<p>No: Pass to RPh. Deny; medical appropriateness.</p>

P&T Review:

12/24; 10/21 (SS); 9/18; 3/16; 7/14; 3/14; 2/12; 9/10

Implementation:

1/1/25; 1/1/22; 11/1/18; 10/13/16; 5/1/16; 5/14/12; 1/24/12; 1/1/11