

Oral/Inhaled Pulmonary Hypertension Agents

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 funded by the Oregon Health Plan (OHP). Note: erectile dysfunction is not funded by the OHP.

Length of Authorization:

- Up to 12 months

Requires PA:

- Non-preferred drugs

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 this an OHP-funded diagnosis?	Yes: Go to #3	No: Pass to RPh. Deny; not funded by the OHP.
3. Is the drug being prescribed by a pulmonologist or cardiologist?	Yes: Go to #4	No: Pass to RPh. Deny; medical appropriateness.
4. Is the request for riociguat (Adempas®) or ambrisentan (Letairis®)?	Yes: Go to #5	No: Go to #6
5. 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 #6
6. Is the patient classified as having World Health Organization (WHO) Functional Class II-IV symptoms?	Yes: Go to #7	No: Pass to RPh. Deny; medical appropriateness.
7. Is there a diagnosis of pulmonary arterial hypertension (PAH) (WHO Group 1; ICD10 I27.0)?	Yes: Go to #8	No: Go to #9

Approval Criteria		
<p>8. Will the prescriber consider a change to a preferred product?</p> <p><u>Note:</u> preferred products do not require PA.</p>	<p>Yes: Inform prescriber of preferred alternatives in class.</p>	<p>No: Approve for 12 months</p>
<p>9. 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 #10</p>
<p>10. Is the request for nebulized treprostinil (Tyvaso®) in a patient with a diagnosis of interstitial lung disease (WHO Group 3; ICD10 I27.23)?</p> <p>Note: treprostinil has not been studied and is not recommended in patients with pulmonary hypertension due to chronic obstructive pulmonary disease.</p>	<p>Yes: Approve for 12 months</p>	<p>No: Go to #11</p>
<p>11. RPh Only: Prescriber must provide supporting literature for use.</p>	<p>Yes: Approve for length of treatment.</p>	<p>No: Deny; not funded by the OHP</p>

P&T Review: 10/21 (SS); 9/18; 3/16; 7/14; 3/14; 2/12; 9/10
Implementation: 1/1/2022; 11/1/2018; 10/13/16; 5/1/16; 5/14/12; 1/24/12; 1/1/11