Clinical Policy: Apixaban (Eliquis®)
Reference Number: MDN.CP.PMN.300
Effective Date: 04.01.22
Last Review Date: 04.22
Line of Business: Illinois Medicaid

Revision Log

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

Description
Eliquis® is selective inhibitor of Factor Xa.

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® that Eliquis® is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Meet one of the following indications**:**

1. Diagnosis of one of the following (a, b, c, d or e):
    a. Reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation
    b. Prophylaxis of deep vein thrombosis (DVT),
    c. Prophylaxis pulmonary embolism (PE)
    d. Treatment of DVT
    e. Treatment of PE
2. Dose does not exceed maximum dose indicated in Section V.

Approve 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): CP.PMN.53 for Medicaid.

II. Continued Therapy A.

(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

Approve 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): 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

DVT: deep vein thrombosis

PE: pulmonary embolism

Appendix B: Contraindications/Boxed Warnings

Active pathological bleeding or severe hypersensitivity reaction to Eliquis®.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation	5 mg orally twice daily Age greater than or equal to 80 years, body weight less than or equal to 60 kg, or serum creatinine greater than or equal to 1.5 mg/dL, the recommended dose is 2.5 mg orally twice daily	10 mg/day
Prophylaxis of DVT and PE following hip or knee replacement surgery	2.5 mg orally twice daily	10 mg/day

Treatment of DVT and PE	10 mg taken orally twice daily for 7 days, followed by 5 mg taken orally twice daily	10 mg/day

References:

1. Eliquis [package insert]. Bristol-Myers Squibb, Princeton, NJ. November 2019. <httppackageinserts.bms.com/pi/pi_eliquis.pdf> Accessed June 30, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created, adopted from IL.PMN.300	03.15.22	04.22

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.

CLINICAL POLICY
Apixaban

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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 (HIM) 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.