Clinical Policy: Insulin Glulisine (Apidra)

Reference Number: CP.CPA.224
Effective Date: 11.16.16
Last Review Date: 11.19
Line of Business: Commercial

Revision Log

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

Description

Insulin glulisine (Apidra®) is a rapid-acting human insulin analog.

FDA Approved Indication(s)

Apidra is indicated to improve glycemic control in adults and children with diabetes mellitus.

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 Apidra is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Diabetes Mellitus (must meet all)**:**

1. Diagnosis of type 1 or type 2 diabetes mellitus;
2. Prescribed in combination with a longer-acting basal insulin analog (e.g., insulin NPH, insulin glargine).

Approval duration: Length of Benefit

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.CPA.09 for commercial.

II. Continued Therapy

A. Diabetes Mellitus (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.

Approval duration: Length of Benefit

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.CPA.09 for commercial.

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 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
  - Use during episodes of hypoglycemia
  - Hypersensitivity to Apidra or any of its excipients
- Boxed warning(s): none reported

Appendix D: General Information

- There are no studies to support the use of Apidra for treatment of obesity.
- Apidra may be infused by external insulin infusion pumps.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Diabetes mellitus	Individualized dose administered SC or IV* within 15 minutes before a meal or within 20 minutes after starting a meal	Not applicable

*If IV: use at concentrations of 0.05 units/mL to 1 unit/mL in 0.9% NaCl; administer under medical supervision in a clinical setting for glycemic control

VI. Product Availability

- U-100 (100 units/mL) vials: 10 mL
- U-100 (100 units/mL) SoloStar® prefilled pen: 3 mL/pen (5 pens/package)

VII. References

1. Apidra Prescribing Information. Bridgewater, NJ: Sanofi-Aventis; December 2018. Available at: www.apidra.com. Accessed July 26, 2019.
2. American Diabetes Association. Standards of medical care in diabetes—2019. Diabetes Care. 2019; 42(suppl 1): S1-S193.
3. Garber AJ, Abrahamson MJ, Barzilay JI, et al. Consensus statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the

comprehensive type 2 diabetes management algorithm – 2019 executive summary. Endocr Pract. 2019; 25(1): 69-204.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template. Minor changes to verbiage and grammar. References updated.	06.06.17	11.17
4Q 2018 annual review: no significant changes; references reviewed and updated.	07.02.18	11.18
4Q 2019 annual review: no significant changes; references reviewed and updated.	07.26.19	11.19

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.

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.