

Clinical Policy: Fluticasone/Umeclidinium/Vilanterol (Trelegy Ellipta)

Reference Number: CP.PMN.146

Effective Date: 05.22.18

Last Review Date: 08.18

Line of Business: Medicaid

[Revision Log](#)

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

Description

Fluticasone/umeclidinium/vilanterol (Trelegy™ Ellipta®) is combination of an inhaled corticosteroid, anticholinergic, and long-acting beta₂-adrenergic agonist.

FDA Approved Indication(s)

Trelegy Ellipta is indicated for the long-term, once-daily, maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD). Trelegy Ellipta is also indicated to reduce exacerbations of COPD in patients with a history of exacerbations.

Limitation(s) of use: Trelegy Ellipta is not indicated for relief of acute bronchospasm or the treatment of asthma.

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 Trelegy Ellipta is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Obstructive Pulmonary Disease (must meet all):

1. Diagnosis of COPD;
2. Age ≥ 18 years;
3. Failure of one of the following (a or b) at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced:
 - a. One long-acting beta-2 agonist (e.g., Serevent®) in combination with one long-acting anticholinergic (e.g., Tudorza® Pressair®, Incruse® Ellipta®);
 - b. One inhaled corticosteroid in combination with a long-acting beta-2 agonist (e.g., Symbicort®);
4. Dose does not exceed 1 inhalation per day (60 blisters per 30 days).

Approval duration: 12 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. Chronic Obstructive Pulmonary Disease (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;
3. If request is for a dose increase, new dose does not exceed 1 inhalation per day (60 blisters per 30 days).

Approval 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 – CP.PMN.53 for Medicaid or evidence of coverage documents;
- B.** Asthma.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

COPD: chronic obstructive pulmonary disease

FDA: Food and Drug Administration

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 for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Incruse Ellipta (umeclidinium)	1 inhalation (62.5 mcg) QD	62.5 mcg/day
Symbicort (budesonide/ formoterol)	2 inhalations of 80/4.5 mcg BID	2 inhalations of 80/4.5 mcg BID
Serevent (salmeterol)	1 inhalation (50 mcg) BID	100 mcg/day
Tudorza Pressair (aclidinium)	1 inhalation (400 mcg) BID	800 mcg/day

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

Appendix C: Contraindications

- Severe hypersensitivity to milk proteins

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
COPD	1 inhalation by mouth QD	1 inhalation/day

VI. Product Availability

Inhalation powder: disposable inhaler containing 2 foil strips of 30 blisters each: one strip with fluticasone furoate (100 mcg per blister), and the other strip with a blend of umeclidinium and vilanterol (62.5 mcg and 25 mcg per blister, respectively)

VII. References

1. Trelegy Ellipta Prescribing Information. Research Triangle Park, NC: GlaxoSmithKline; April 2018. Available at: www.trelegyellipta.com. Accessed May 3, 2018.
2. Global Initiative for Chronic Obstructive Lung Disease (GOLD). Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease (2018 report). Published January 2018. Available at: <http://www.goldcopd.org/>. Accessed April 9, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created.	05.22.18	08.18

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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