Clinical Policy: Epinephrine (Auvi-Q, EpiPen, EpiPen Jr) Quantity Limit Override

Reference Number: CP.PMN.144
Effective Date: 08.01.16
Last Review Date: 08.20 Revision Log
Line of Business: Medicaid

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

Description

Epinephrine (Auvi-Q®, EpiPen®, EpiPen Jr®) is a non-selective alpha and beta-adrenergic receptor agonist.

FDA Approved Indication(s)

Auvi-Q, EpiPen, and EpiPen Jr are indicated in the emergency treatment of allergic reactions (Type I) including anaphylaxis.

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 a quantity of Auvi-Q, EpiPen and/or EpiPen Jr in excess of 4 pens per 365 days is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Auvi-Q/EpiPen/EpiPen Jr in Excess of 4 Pens per 365 Days (must meet all)**:**

1. One of the following requirements is met (a or b):
   a. Provider submits documentation supporting the use of previous Auvi-Q, EpiPen, or EpiPen Jr fills, including the date(s) of use, and that immediate medical or hospital care was received in conjunction with administration of Auvi-Q, EpiPen, or EpiPen Jr;
   b. Provider submits documentation supporting that the most recent fill for Auvi-Q, EpiPen, or EpiPen Jr has expired, including the expiration date.

Approval duration: one Auvi-Q 2-pack, one EpiPen 2-Pak, or one EpiPen Jr 2-Pak

B. Other diagnoses/indications: Not applicable

II. Continued Therapy

A. Auvi-Q/EpiPen/EpiPen Jr in Excess of 4 Pens per 365 Days

1. Continuation of therapy will not be granted. Member must be evaluated against the initial approval criteria.

Approval duration: Not applicable

B. Other diagnoses/indications: Not applicable

III. Diagnoses/Indications for which coverage is NOT authorized: Not applicable

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
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Epinephrine (Auvi-Q)	IM/SC into the anterolateral aspect of the thigh: Greater than or equal to 30 kg (66 lbs): 0.3 mg 15 to 30 kg (33 lbs to 66 lbs): 0.15 mg 7.5 to 15 kg (16.5 to 33 lbs): 0.1 mg	2 sequential doses
Epinephrine (EpiPen)	Greater than or equal to 30 kg (66 lbs): 0.3 mg IM/SC into the anterolateral aspect of the thigh	2 sequential doses (0.6 mg)
Epinephrine (EpiPen Jr)	15 to 30 kg (33 lbs to 66 lbs): 0.15 mg IM/SC into the anterolateral aspect of the thigh	2 sequential doses (0.3 mg)

VI. Product Availability

Drug Name	Availability
Epinephrine (Auvi-Q)	Pre-filled auto-injector: 0.3 mg/0.3 mL, 0.15 mg/0.15 mL, 0.1 mg/0.1 mL (2 auto-injectors per package)
Epinephrine (EpiPen)	Pre-filled auto-injector: 0.3 mg/0.3 mL (2 pens per package)
Epinephrine (EpiPen Jr)	Pre-filled auto-injector: 0.15 mg/0.3 mL (2 pens per package)

VII. References

1. EpiPen and EpiPen Jr Prescribing Information. Morgantown, WV: Mylan Specialty L.P.; January 2020. Available at https://www.epipen.com/. Accessed April 6, 2020.
2. Auvi-Q Prescribing Information. Richmond, VA: Kaleo, Inc.; September 2019. Available at https://www.auvi-q.com/. Accessed April 6, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy.	07.16	08.16
Converted to new template.	03.17	08.17
3Q 2018 annual review: no significant changes; references reviewed and updated.	04.05.18	08.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2019 annual review: added Auvi-Q to the policy since it has the same quantity limit on Medicaid as EpiPen and EpiPen Jr.; references reviewed and updated.	05.15.19	08.19
3Q 2020 annual review: no significant changes; references reviewed and updated.	04.06.20	08.20

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.

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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