

**Clinical Policy: Fondaparinux (Arixtra)****Reference Number: LA.PHAR.226****Effective Date:****Last Review Date: 06.21****Line of Business: Medicaid****Coding Implications****Revision Log**

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

**Description**

**Fondaparinux (Arixtra®) is a synthetic factor Xa inhibitor.**

**FDA Approved Indication(s)****Arixtra is indicated:**

- **For prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE) in patients undergoing:**
  - **Hip fracture surgery, including extended prophylaxis;**
  - **Hip replacement surgery;**
  - **Knee replacement surgery;**
  - **Abdominal surgery who are at risk for thromboembolic complications.**
- **For treatment of acute DVT when administered in conjunction with warfarin sodium.**
- **For treatment of acute PE when administered in conjunction with warfarin sodium when initial therapy is administered in the hospital.**

**Policy/Criteria**

**Prior authorization is required. Provider must submit documentation (including such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.**

**It is the policy of Louisiana Healthcare Connections that Arixtra is medically necessary when the following criteria are met:**

**I. Initial Approval Criteria****A. Thrombosis/Thromboembolism\* (must meet all):****1. Any of the following indications (a, b, or c):****a. Thrombosis or thromboembolism prevention associated with any of the following conditions:**

- i. **Cancer (see Appendix D);**
- ii. **Unstable angina or myocardial infarction;**
- iii. **Major surgery - orthopedic or non-orthopedic;**
- iv. **Critical illness related to ICU admissions or events;**
- v. **Restricted mobility associated with acute illnesses or conditions;**
- vi. **Implanted devices-vascular (e.g., central venous access device, umbilical venous catheter, devices/fistulas related to hemodialysis, ventricular assist devices);**

**b. Thrombosis or thromboembolism treatment;**

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- c. Short-term prophylaxis for transition to or from oral anticoagulation;
2. Failure of a trial of enoxaparin unless (a, b, or c):
  - a. Enoxaparin is contraindicated;
  - b. History of clinically significant adverse effects or allergy to low molecular weight heparin (LMWH; enoxaparin or dalteparin) or heparin (e.g., history of heparin-induced thrombocytopenia [HIT]);
  - c. The requested use is FDA labeled for fondaparinux but not for enoxaparin (i.e., hip fracture surgery prophylaxis; PE treatment);
3. If request is for Arixtra, medical justification supports inability to use generic fondaparinux (e.g., contraindications to excipients in fondaparinux).

Approval duration:

Medicaid - 6 months

*\*Includes off-label use for adults and pediatrics.*

#### B. Anticoagulation in Pregnancy: Ante- and Postpartum (off-label) (must meet all):

1. Any of the following indications:
  - a. Acute venous thrombosis during current pregnancy;
  - b. Prior venous thrombosis;
  - c. Receiving long-term therapy with a vitamin K antagonist (e.g., warfarin);
  - d. Prosthetic heart valve;
  - e. Inherited thrombophilia;
  - f. Antiphospholipid antibody syndrome;
  - g. Development of severe ovarian hyperstimulation syndrome post assisted reproduction;
  - h. Cesarean section – current pregnancy and request is for the postpartum period;
  - i. Any other indication not listed here that is listed in section I.A.
2. Member is pregnant or < 6 months postpartum;
3. History of clinically significant adverse effects or allergy to LMWH or heparin (e.g. HIT);
4. If request is for Arixtra, medical justification supports inability to use generic fondaparinux (e.g., contraindications to excipients in fondaparinux).

Approval duration:

Medicaid – Antepartum (to estimated delivery date); postpartum (6 months)

#### C. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.PMN.53 for Medicaid.

## II. Continued Therapy

#### A. Thrombosis/Thromboembolism (must meet all):

1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;

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2. Member is responding positively to therapy;
3. Continued use is limited to any of the following indications (a, b, or c):
  - a. Venous thrombosis prophylaxis or treatment in the presence of cancer;
  - b. Past history of failed anticoagulation therapy (clot development) on warfarin;
  - c. Any other indication in section I.A where bridging to warfarin is inappropriate or member has a contraindication to warfarin and extended (indefinite duration) anticoagulation therapy is required;
4. If request is for Arixtra, medical justification supports inability to use generic fondaparinux (e.g., contraindications to excipients in fondaparinux).

Approval duration:

Medicaid - 6 months

- B. Anticoagulation in Pregnancy: Ante- and Postpartum (off-label) (must meet all):
1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
  2. Member is responding positively to therapy;
  3. See Section II.A for continued anticoagulation therapy beyond 6 months postpartum;
  4. If request is for Arixtra, medical justification supports inability to use generic fondaparinux (e.g., contraindications to excipients in fondaparinux).

Approval duration:

Medicaid – Antepartum (to estimated delivery date); postpartum (6 months)

- C. Other diagnoses/indications (must meet 1 or 2):
1. Currently receiving medication via Louisiana Healthcare Connections benefit and documentation supports positive response to therapy.  
Approval duration: Duration of request or 6 months (whichever is less); or
  2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): LA.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 policy – LA.PMN.53 for Medicaid.

### IV. Appendices/General Information

#### Appendix A: Abbreviation/Acronym Key

DVT: deep vein thrombosis

HIT: heparin-induced thrombocytopenia

LMWH: low molecular weight heparin

NCCN: National Comprehensive Cancer Network

PE: pulmonary embolism

#### Appendix B: Therapeutic Alternatives

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may require prior authorization.*

<u>Drug Name</u>	<u>Dosing Regimen</u>	<u>Dose Limit/ Maximum Dose</u>
<u>enoxaparin (Lovenox®) - Adults</u>	<u>DVT prophylaxis in abdominal surgery</u> <u>40 mg SC once daily</u> <u>DVT prophylaxis in knee replacement surgery</u> <u>30 mg SC every 12 hours</u> <u>DVT prophylaxis in hip replacement surgery</u> <u>30 mg SC every 12 hours or 40 mg SC once daily</u> <u>DVT prophylaxis in medical patients</u> <u>40 mg SC once daily</u> <u>Inpatient treatment or acute DVT with or without PE</u> <u>1 mg/kg SC every 12 hours or 1.5 mg/kg SC once daily</u> <u>Outpatient treatment of acute DVT without PI</u> <u>1 mg/kg SC every 12 hours</u> <u>Unstable angina and non-Q wave MI</u> <u>1 mg/Kg SC every 12 hours (with aspirin)</u>	<u>Dose as specified; duration may vary.</u>

*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/Boxed Warnings

- Contraindication(s):
  - Severe renal impairment (creatinine clearance [CrCl] <30 mL/min)
  - Active major bleeding
  - Bacterial endocarditis
  - Thrombocytopenia associated with a positive in vitro test for anti-platelet antibody in the presence of fondaparinux sodium.
  - Body weight <50 kg (venous thromboembolism [VTE] prophylaxis only)
  - History of serious hypersensitivity reaction (e.g., angioedema, anaphylactoid/anaphylactic reactions) to Arixtra
- Boxed warning(s): Spinal/epidural hematomas

#### Appendix D: General information

- National Comprehensive Cancer Network (NCCN) guidelines for cancer-associated venous thromboembolic disease, fondaparinux is recommended for:
  - Anticoagulation for acute and chronic management of acute superficial vein thrombosis, management of chronic splanchnic vein thrombosis in cancer patients, management of acute splanchnic vein thrombosis, anticoagulation for acute DVT, acute catheter-related DVT, and/or acute pulmonary embolism in cancer patients with no contraindication to anticoagulation:
    - as monotherapy

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- for 5 - 10 days given concurrently with warfarin monotherapy
- Anticoagulation for cancer patients following therapeutic anticoagulation failure with: heparin sodium, low-molecular weight heparin, warfarin sodium, apixaban, dabigatran, edoxaban, or rivaroxaban
- Venous thromboembolism prophylaxis for adult patients with no contraindication to anticoagulation
  - for inpatient medical and/or surgical patients with cancer or those for whom a clinical suspicion of cancer exists
  - for outpatient surgical patients with cancer for up to 4 weeks following high-risk surgery (e.g., abdominal/pelvic)
- Initial treatment for suspected or confirmed heparin-induced thrombocytopenia following discontinuation of heparin-based products in clinically stable patients with no contraindications and without hemodynamically unstable pulmonary embolism, limb-threatening thrombosis, or planned invasive procedures

#### V. Dosage and Administration

<u>Indication</u>	<u>Dosing Regimen</u>	<u>Maximum Dose</u>
<b><u>Adults</u></b>		
<u>DVT prophylaxis following hip fracture, hip replacement, and knee replacement surgery and abdominal surgery</u>	<u>2.5 mg SC per day</u>	<u>2.5 mg per day</u>
<u>Acute DVT/PE treatment</u>	<u>SC based on body weight:</u> <u>&lt; 50 kg: 5 mg per day</u> <u>50 to 100 kg: 7.5 mg per day</u> <u>&gt; 100 kg: 10 mg per day</u>	<u>10 mg per day</u>

#### VI. Product Availability

Single-dose, prefilled syringes: 2.5 mg, 5 mg, 7.5 mg, or 10 mg

#### VII. References

1. Arixtra Prescribing Information. Rockford, IL: Mylan Institutional, LLC. December 2019. Available at [https://www.accessdata.fda.gov/drugsatfda\\_docs/label/2019/021345s037lbl.pdf](https://www.accessdata.fda.gov/drugsatfda_docs/label/2019/021345s037lbl.pdf). Accessed November 16, 2020.
2. Executive summary: Antithrombotic therapy and prevention of thrombosis: CHEST guidelines and expert panel reports. Available at <http://www.chestnet.org/Guidelines-and-Resources/CHEST-Guideline-Topic-Areas/Pulmonary-Vascular>. Accessed November 6, 2020. *The CHEST guideline series presents recommendations for the prevention, diagnosis, and treatment of thrombosis, addressing a comprehensive list of clinical conditions, including medical, surgery, orthopedic surgery, atrial fibrillation, stroke, cardiovascular disease, pregnancy, and neonates and children.*
3. Thromboembolism in pregnancy. Practice Bulletin No. 196. American College of Obstetrics and Gynecologists. *Obstet Gynecol.* July 2018; 132: e1-17.

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4. National Comprehensive Cancer Network. Cancer-Associated Venous Thromboembolic Disease Version 1.2020. Available at: <http://www.nccn.org>.
5. Arixtra. National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed November 7, 2020.
6. Kearon C, Akl EA, Omelas J, et al. Antithrombotic Therapy for VTE Disease: CHEST Guideline and Expert Panel Report. *Chest* 2016;149:315-352.
7. Ortel TL, Neumann I, Ageno W, et al. American Society of Hematology 2020 guidelines for management of venous thromboembolism: treatment of deep vein thrombosis and pulmonary embolism. *Blood Adv.* 2020 Oct 13;4(19):4693-38.

#### Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

<u>HCPCS Codes</u>	<u>Description</u>
<b>J1652</b>	<b>Injection, fondaparinux sodium, 0.5 mg</b>

<u>Reviews, Revisions, and Approvals</u>	<u>Date</u>
<b>Converted corporate to local policy</b>	<b>06.2021</b>

#### 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. LHCC 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.

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