Clinical Policy: Fondaparinux (Arixtra)
Reference Number: ERX.SPA.206
Effective Date: 01.11.17
Last Review Date: 11.17

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

Description
Fondaparinux (Arixtra®) is a factor Xa inhibitor (anticoagulant).

FDA Approved Indication(s)
Arixtra is indicated:
- For the prophylaxis of deep vein thrombosis (DVT) in patients undergoing hip fracture surgery (including extended prophylaxis), hip replacement surgery, knee replacement surgery, or abdominal surgery
- For the treatment of DVT or acute pulmonary embolism (PE) when administered in conjunction with warfarin

Policy/Criteria
Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Arixtra is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Venous Thrombosis (must meet all):
      1. Any of the following indications (a or b):
         a. Prophylaxis of venous thrombosis (i, ii, iii, iv, or v):
            i. Surgery (a, b, c, or d):
               a) Total hip or knee replacement surgery;
               b) Hip fracture surgery;
               c) Other major orthopedic surgery including spinal surgery;
               d) General and abdominal-pelvic surgery;
            ii. Critical illness;
            iii. Restricted mobility:
               a) In medical patients who are at risk for thromboembolic complications due to severely restricted mobility during acute illness;
            iv. Unstable angina and non-Q-wave myocardial infarction;
            v. Cancer;
         b. Treatment of venous thrombus (i, ii, or iii):
            i. DVT or PE;
            ii. Superficial vein thrombus;
            iii. Splanchnic (gastric, small/large intestine [mesentery venous thrombosis], pancreatic, hepatic [portal], splenic) vein thrombosis;
      2. Age ≥ 18 years;
      3. Request is for treatment in the outpatient setting;
      4. Failure of a trial of enoxaparin unless contraindicated or clinically significant adverse effects are experienced;
      5. At the time of request, member does not weigh < 50 kg (venous thromboembolism prophylaxis only);
      6. Dose does not exceed 10 mg per day (1 syringe/day).
   Approval duration: 6 months

   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;

2. Member has a history of a severe allergy to heparin (e.g., heparin-induced thrombocytopenia);
3. Member is pregnant or < 6 months postpartum;
4. Request is for treatment in the outpatient setting.

**Approval duration:**
- Antepartum: to estimated delivery date
- Postpartum: to 6 months postpartum (3 month approvals)

### C. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

### II. Continued Therapy

**A. Venous Thrombosis** (must meet all):

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions or member has previously met initial approval criteria;
2. Continued use is limited to one of the following (a or b):
   a. Venous thrombosis prophylaxis or treatment in the presence of cancer;
   b. 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;
3. If request is for a dose increase, new dose does not exceed 10 mg/day (1 syringe per day).

**Approval duration:** 12 months

**B. Other diagnoses/indications** (must meet 1 or 2):

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.

   **Approval duration:** Duration of request or 6 months (whichever is less); or

2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

### 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 – ERX.PA.01 or evidence of coverage documents.

### IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*

DVT: deep vein thrombosis
PE: pulmonary embolism
Appendix B: Therapeutic Alternatives

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>enoxaparin (Lovenox®)</td>
<td>Prophylaxis:</td>
<td>Varies</td>
</tr>
<tr>
<td></td>
<td>In abdominal surgery</td>
<td></td>
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<tr>
<td></td>
<td>40 mg SC once daily</td>
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<tr>
<td></td>
<td>In knee replacement surgery</td>
<td></td>
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<tr>
<td></td>
<td>30 mg SC every 12 hours</td>
<td></td>
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<tr>
<td></td>
<td>In hip replacement surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>30 mg SC every 12 hours or 40 mg SC once daily</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In medical patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>40 mg SC once daily</td>
<td></td>
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<tr>
<td></td>
<td>Treatment:</td>
<td></td>
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<tr>
<td></td>
<td>Acute DVT with or without PE, inpatient</td>
<td>1 mg/kg SC every 12 hours or 1.5 mg/kg SC once daily</td>
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<tr>
<td></td>
<td>Acute DVT without PE, outpatient</td>
<td>1 mg/kg SC every 12 hours</td>
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<tr>
<td></td>
<td>Unstable angina and non-Q-wave myocardial infarction</td>
<td>1 mg/kg SC every 12 hours (with aspirin)</td>
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<tr>
<td></td>
<td>Acute STEMI</td>
<td>Age &lt; 75 years: 30 mg single IV bolus plus a 1 mg/kg SC dose followed by 1 mg/kg SC every 12 hours (with aspirin) Age ≥ 75 years: 0.75 mg/kg SC every 12 hours (no bolus) (with aspirin)</td>
</tr>
</tbody>
</table>

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.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>DVT prophylaxis</td>
<td>2.5 mg SC per day</td>
<td>2.5 mg per day</td>
</tr>
<tr>
<td>DVT treatment</td>
<td>SC based on body weight:</td>
<td>10 mg per day</td>
</tr>
<tr>
<td></td>
<td>&lt; 50 kg: 5 mg per day</td>
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<tr>
<td></td>
<td>50 to 100 kg: 7.5 mg per day</td>
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<tr>
<td></td>
<td>&gt; 100 kg: 10 mg per day</td>
<td></td>
</tr>
</tbody>
</table>

VI. Product Availability

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

VII. References

**Clinical Policy**

**Fondaparinux**

### Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
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<tbody>
<tr>
<td>Policy created.</td>
<td>12.01.16</td>
<td>01.17</td>
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<tr>
<td>4Q17 Annual Review</td>
<td>09.28.17</td>
<td>11.17</td>
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<tr>
<td>Converted to new template.</td>
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<tr>
<td>Added age and contraindication of weight &lt; 50 kg. Updated approval duration from 3/6 months to 6/12 months. Section I.A. Criteria are edited to follow CHEST 2012 and 2016 guidelines (which for the most part include NCCN and ACOG guidelines) in addition to labeled indications. Major additions include 1) prophylaxis: major orthopedic, general surgery; critical illness; restricted mobility due to acute illness; 2) treatment: SVT, splanchnic thrombosis without cancer. HIT is added to bypass enoxaparin preferencing. Warfarin bridging criteria are moved to renewal criteria. Section I.B. Pregnancy criteria are added for cases of HIT. Section II. Criteria are edited to follow CHEST 2016 guidelines. Major additions include any other indication in section I.A. where bridging to warfarin is inappropriate or member has a contraindication to warfarin and extended (indefinite) anticoagulation therapy is required.</td>
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</table>

### 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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.

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