

Clinical Policy: Selexipag (Uptravi)

Reference Number: ERX.SPA.39

Effective Date: 07.01.16

Last Review Date: 02.22

Line of Business: Commercial, Medicaid

[Revision Log](#)

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

Description

Selexipag (Uptravi[®]) is a prostacyclin receptor agonist.

FDA Approved Indication(s)

Uptravi is indicated for the treatment of pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1) to delay disease progression and reduce the risk of hospitalization for PAH.

Effectiveness was established in a long-term study in PAH patients with WHO Functional Class II-III symptoms. Patients had idiopathic and heritable PAH (58%), PAH associated with connective tissue disease (29%), and PAH associated with congenital heart disease with repaired shunts (10%).

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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

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

I. Initial Approval Criteria

A. Pulmonary Arterial Hypertension (must meet all):

1. Diagnosis of PAH;
2. Prescribed by or in consultation with a cardiologist or pulmonologist;
3. Failure of a calcium channel blocker (*see Appendix B*), unless member meets one of the following (a or b):
 - a. Inadequate response or contraindication to acute vasodilator testing;
 - b. Contraindication or clinically significant adverse effects to calcium channel blockers are experienced;
4. Dose does not exceed 3,200 mcg per day (*if request is for titration, provider must submit a titration plan*).

Approval duration: 6 months

B. 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. Pulmonary Arterial Hypertension (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. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 3,200 mcg per day (*if request is for titration, provider must submit a titration plan*).

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

FC: functional class

FDA: Food and Drug Administration

NYHA: New York Heart Association

PAH: pulmonary arterial hypertension

PH: pulmonary hypertension

WHO: World Health Organization

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
nifedipine (Adalat® CC, Afeditab® CR, Procardia®, Procardia XL®)	60 mg PO QD; may increase to 120 to 240 mg/day	240 mg/day
diltiazem (Dilacor XR®, Dilt-XR®, Cardizem® CD, Cartia XT®, Tiazac®, Taztia XT®, Cardizem® LA, Matzim® LA)	720 to 960 mg PO QD	960 mg/day
amlodipine (Norvasc®)	20 to 30 mg PO QD	30 mg/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: Contraindication/Boxed Warnings

None reported

Appendix D: Pulmonary Hypertension: WHO Classification

- Group 1: PAH (pulmonary arterial hypertension)
- Group 2: PH due to left heart disease
- Group 3: PH due to lung disease and/or hypoxemia
- Group 4: CTEPH (chronic thromboembolic pulmonary hypertension)
- Group 5: PH due to unclear multifactorial mechanisms

Appendix E: Pulmonary Hypertension: WHO/NYHA Functional Classes (FC)

Treatment Approach*	FC	Status at Rest	Tolerance of Physical Activity (PA)	PA Limitations	Heart Failure
Monitoring for progression of PH and treatment of co-existing conditions	I	Comfortable at rest	No limitation	Ordinary PA does not cause undue dyspnea or fatigue, chest pain, or near syncope	
Advanced treatment of PH	II	Comfortable at rest	Slight limitation	Ordinary PA causes undue dyspnea or	

Treatment Approach*	FC	Status at Rest	Tolerance of Physical Activity (PA)	PA Limitations	Heart Failure
with PH-targeted therapy - see Appendix F**				fatigue, chest pain, or near syncope	
	III	Comfortable at rest	Marked limitation	Less than ordinary PA causes undue dyspnea or fatigue, chest pain, or near syncope	
	IV	Dyspnea or fatigue may be present at rest	Inability to carry out any PA without symptoms	Discomfort is increased by any PA	Signs of right heart failure

*PH supportive measures may include diuretics, oxygen therapy, anticoagulation, digoxin, exercise, and pneumococcal vaccination. **Advanced treatment options also include calcium channel blockers.

Appendix F: Pulmonary Hypertension: Targeted Therapies

Mechanism of Action	Drug Class	Drug Subclass	Drug	Brand/Generic Formulations
Reduction of pulmonary arterial pressure through vasodilation	Prostacyclin* pathway agonist <i>*Member of the prostanoid class of fatty acid derivatives</i>	Prostacyclin	Epoprostenol	Veletri (IV) Flolan (IV) Flolan generic (IV)
		Synthetic prostacyclin analog	Treprostinil	Orenitram (oral tablet) Remodulin (IV) Tyvaso (inhalation)
			Iloprost	Ventavis (inhalation)
		Non-prostanoid prostacyclin receptor (IP receptor) agonist	Selexipag	Upravi (oral tablet)
	Endothelin receptor antagonist	Selective receptor antagonist	Ambrisentan	Letairis (oral tablet)
		Nonselective dual action receptor antagonist	Bosentan	Tracleer (oral tablet)
			Macitentan	Opsumit (oral tablet)
	Nitric oxide-cyclic guanosine monophosphate enhancer	Phosphodiesterase type 5 (PDE-5) inhibitor	Sildenafil	Revatio (IV, oral tablet, oral suspension)
			Tadalafil	Adcirca (oral tablet)
		Guanylate cyclase stimulant	Riociguat	Adempas (oral tablet)

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
PAH	200 mcg PO BID, increased at weekly intervals to highest tolerated dose up to 1,600 mcg BID	3,200 mcg/day

VI. Product Availability

Tablets: 200 mcg, 400 mcg, 600 mg, 800 mg, 1,000 mcg, 1,200 mcg, 1,400 mcg, 1,600 mcg

VII. References

1. Upravi Prescribing Information. South San Francisco, CA: Actelion Pharmaceuticals US, Inc.; October 2021. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2021/207947s009lbl.pdf. Accessed November 9, 2021.
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Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q18 annual review: Converted to new template. Removed WHO/NYHA classification from initial criteria. References reviewed and updated.	11.21.17	02.18
1Q 2019 annual review: no significant changes; references reviewed and updated.	11.20.18	02.19
1Q 2020 annual review: no significant changes; added statement that titration plan be submitted; references reviewed and updated.	11.26.19	02.20
1Q 2021 annual review: no significant changes; references reviewed and updated.	10.12.20	02.21
1Q 2022 annual review: no significant changes; references reviewed and updated.	11.09.21	02.22

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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