Clinical Policy: Teduglutide (Gattex)

Reference Number: IL. PHAR.114
Effective Date: 1.1.20
Last Review Date: 04.25.22
Line of Business: Medicaid

Revision Log

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

Description

Teduglutide (Gattex®) is a glucagon-like peptide-2 analog.

FDA Approved Indication(s)

Gattex is indicated for treatment of adult and pediatric patients 1 year of age and older with short bowel syndrome (SBS) who are dependent on parenteral support.

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 Gattex is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Short Bowel Syndrome (must meet all):

1. Diagnosis of SBS;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 1 year;
4. Dependent on parenteral nutrition or other intravenous support for ≥ 12 months;
5. If age ≥ 18 years, failure of a 4-week trial of somatropin (e.g., Genotropin®) unless contraindicated or clinically significant adverse effects are experienced;
   **Prior authorization is (or may be) required for somatropin.*
6. Dose does not exceed 0.05 mg/kg per day.

Approval duration:
Medicaid – 12 months

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the PDL (Medicaid), the no coverage criteria policy for the relevant line of businesss: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND

criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Short Bowel Syndrome (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*
   c.
2. Requirement for parenteral nutrition or other intravenous support has decreased since initiation of Gattex therapy;
3. If request is for a dose increase, new dose does not exceed 0.05 mg/kg per day.

Approval duration:
Medicaid – 12 months

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: 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 policy – CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
SBS: short bowel syndrome

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
somatropin (e.g., Genotropin)	Refer to prescribing information (*Somatropin, rh-GH doses must be individualized and are highly*	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	variable depending on the nature and severity of the disease, the formulation being used, and on patient response)	

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
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
SBS	0.05 mg/kg SC QD	0.05 mg/kg/day

VI. Product Availability

Single-use vial: 5 mg

VII. References

1. Gattex Prescribing Information. Lexington, MA: Shire-NPS Pharmaceuticals, Inc.; January 2021. Available at http://www.gattex.com. Accessed April 25, 2022.
2. Parrish CR, DiBaise JK. Managing the adult patient with short bowel syndrome. *Gastroenterology & Hepatology*. October 2017; 13(10): 600-608.
3. Seidner DL, Schwartz LK, Winkler MF, et al. Increased intestinal absorption in the era of teduglutide and its impact on management strategies in patients with short bowel syndrome – associated intestinal failure. *JPEN.* 2013; 37: 201-2011.

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.

HCPCS Codes	Description
J3490	Unclassified drugs

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New policy created, adapted CP.PHAR.114 Teduglutide (Gattex) policy.	12.6.19	
1Q 2020 annual review: somatropin trial limited to adults and Norditropin is designated as a preferred drug; references reviewed and updated.	12.30.19	1.7.20
2Q2021 annual review: no significant changes. reference reviewed and updated	4.15.21	
2Q2022 annual review: added coding implication section; references reviewed and updated	4.25.22	
Template changes applied to other diagnoses/indications and continued therapy section.	10.27.22	

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. 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.