Clinical Policy Title:	ambrisentan
Policy Number:	RxA.203
Drug(s) Applied:	ambrisentan, Letairis®
Original Policy Date:	02/07/2020
Last Review Date:	08/28/2024
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Pulmonary arterial hypertension (PAH) (must meet all):

1. Diagnosis of PAH;
2. Trial and failure of at least one (1) calcium channel blocker, 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;

Approval Duration

All Lines of Business (except Medicare): 6 months

II. Continued Therapy Approval

A. Pulmonary arterial hypertension (must meet all)**:**

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy.

Approval Duration

All Lines of Business (except Medicare): 12 months

References

1. Taichman D, Ornelas J, Chung L, et al. CHEST guideline and expert panel report: Pharmacologic therapy for pulmonary arterial hypertension in adults. Chest. 2014; 146 (2): 449-475. Available at: https://pubmed.ncbi.nlm.nih.gov/24937180/. Accessed August 28, 2024.
2. Abman SH, Hansmann G, Archer SL, et al. Pediatric pulmonary hypertension: Guidelines from the American Heart Association and American Thoracic Society. Circulation. 2015 Nov 24; 132(21): 2037-99. Available at: https://pubmed.ncbi.nlm.nih.gov/26534956/. Accessed August 28, 2024.
3. Kim NH, Delcroix M, Jenkins DP, et al. Chronic thromboembolic pulmonary hypertension.J Am Coll Cardiol 2013; 62(25): Suppl D92-99. Available at: https://pubmed.ncbi.nlm.nih.gov/24355646/. Accessed August 28, 2024.
4. Galiè N, Humbert M, Vachiary JL, et al. 2015 ESC/ERS Guidelines for the diagnosis and treatment of Pulmonary Hypertension. European Heart Journal. Doi:10.1093/eurheartj/ehv317. Available at: https://pubmed.ncbi.nlm.nih.gov/26320113/. Accessed August 28, 2024.

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	01/2020	02/07/2020

Policy was reviewed: 1. Policy description table was updated 2. Continuation therapy criteria II.A.1. was rephrased to “Member is currently receiving medication that has been authorized by RxAdvance…” 3. Initial therapy and continued therapy approval duration for “commercial” was updated from length of benefit to 6 months and 12 months respectively. 4. References were updated	06/15/2020	09/14/2020
Policy was reviewed: 1. Age criteria was added to Initial approval criteria I.A.3. 2. References were reviewed and updated.	03/04/2021	06/10/2021
Policy was reviewed: 1. References were reviewed and updated.	01/17/2022	04/18/2022
Policy was reviewed: 1. References were reviewed and updated.	02/15/2023	04/13/2023
Policy was reviewed.	10/19/2023	10/19/2023
Policy was reviewed: 1. Added generic ambrisentan to Drug(s) Applied. 2. Removed prescriber restrictions. 3. Removed age restrictions. 4. Removed dose restrictions. 5. Updated Continued therapy approval with auto-approval based on lookback functionality within the past 120 days. 6. Removed reauthorization requirement for positive response to therapy. 7. Updated approval duration verbiage. 8. References were reviewed and updated.	08/28/2024	09/13/2024