Clinical Policy: Vardenafil (Levitra, Staxyn)
Reference Number: CP.CPA.324
Effective Date: 06.01.18
Last Review Date: 08.19
Line of Business: Commercial

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

Description
Vardenafil (Levitra®, Staxyn™) is a phosphodiesterase-5 inhibitor.

FDA Approved Indication(s)
Levitra and Staxyn are indicated for the treatment of erectile dysfunction (ED).

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 Levitra and Staxyn are medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Erectile Dysfunction (must meet all):
      1. Diagnosis of ED;
      2. Age ≥ 18 years;
      3. Requested agent is on the formulary;
      4. Failure of generic Viagra® (sildenafil 25 mg, 50 mg, 100 mg) unless contraindicated or clinically significant adverse effects are experienced;
      5. Member is NOT on nitrates or guanylate cyclase stimulators;
      6. Dose does not exceed health plan approved quantity limit and the following:
         a. Levitra: 20 mg/day (1 tablet);
         b. Staxyn: 10 mg/day (1 tablet).

   Approval duration: Length of Benefit

   B. Other diagnoses/indications
      1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.

II. Continued Therapy
   A. Erectile Dysfunction (must meet all):
      1. Currently receiving medication via Centene benefit 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 health plan approved quantity limit and the following:
   a. Levitra: 20 mg/day (1 tablet);
   b. Staxyn: 10 mg/day (1 tablet).

**Approval duration: Length of Benefit**

**B. Other diagnoses/indications (must meet 1 or 2):**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   **Approval duration: Duration of request or 12 months (whichever is less); or**
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial.

**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 policies – CP.CPA.09 for commercial or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*
ED: erectile dysfunction
FDA: Food and Drug Administration

*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 for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sildenafil (Viagra)</td>
<td>50 mg PO 1 hour (0.5 - 4 hours) before sexual activity</td>
<td>100 mg/day</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.

*Appendix C: Contraindications/Boxed Warnings*
- Contraindication(s): administration with nitrates, nitric oxide donors, or guanylate cyclase (GC) stimulators, such as Adempas® (riociguat)
- Boxed warning(s): none reported

**V. Dosage and Administration**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>10 mg PO 60 minutes before sexual activity</td>
<td>Staxyn: 10 mg/day Levitra: 20mg/day</td>
</tr>
</tbody>
</table>
VI. Product Availability

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vardenafil (Levitra)</td>
<td>Tablet: 2.5 mg, 5 mg, 10 mg, 20 mg</td>
</tr>
<tr>
<td>Vardenafil (Staxyn)</td>
<td>Orally disintegrating tablet: 10 mg</td>
</tr>
</tbody>
</table>

VII. References


Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Description</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2Q 2018 annual review: no significant changes; policy split from CP.CPA.277 phosphodiesterase-5 inhibitor; changed approved duration from member’s renewal date to 12 months; references reviewed and updated.</td>
<td>02.23.18</td>
<td>05.18</td>
</tr>
<tr>
<td>Added redirection to sildenafil. Modified approval duration to length of benefit.</td>
<td>05.23.18</td>
<td>08.18</td>
</tr>
<tr>
<td>3Q 2019 annual review: No significant changes; references reviewed and updated.</td>
<td>05.01.19</td>
<td>08.19</td>
</tr>
</tbody>
</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. 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.
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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.

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