Clinical Policy: Rivaroxaban (Xarelto)
Reference Number: CP.PMN.247
Effective Date: 09.01.20
Last Review Date: 08.20
Line of Business: Medicaid

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

Description
Rivaroxaban (Xarelto®) is a factor Xa inhibitor.

FDA Approved Indication(s)
Xarelto is indicated:
- To reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation (NVAF)
- For the treatment of deep venous thrombosis (DVT)
- For the treatment of pulmonary embolism (PE)
- For the reduction in the risk of recurrence of DVT and/or PE in patients at continued risk for recurrent DVT and/or PE after completion of initial treatment lasting at least 6 months
- For the prophylaxis of DVT, which may lead to PE in patients who have undergoing knee or hip replacement surgery
- For the prophylaxis of venous thromboembolism (VTE) and VTE related death during hospitalization and post hospital discharge in adult patients admitted for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE and not at high risk of bleeding
- In combination with aspirin, to reduce the risk of major cardiovascular events (cardiovascular death, myocardial infarction and stroke) in patients with chronic coronary artery disease or peripheral artery disease.

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 Xarelto is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. All FDA-approved Indications (must meet all):
      1. Prescribed for one of the following conditions (a - e):
         a. Reduction of the risk of stroke and systemic embolism in member with NVAF;
         b. Treatment and risk reduction of DVT or PE;
         c. Prophylaxis of DVT or PE in those who have undergone knee or hip replacement surgery;
         d. Continuation of VTE prophylaxis following hospital discharge and member was admitted for an acute medical illness at risk for thromboembolic complications;
e. To reduce the risk of major cardiovascular events (cardiovascular death, myocardial infarction and stroke) in patients with chronic coronary artery disease or peripheral artery disease and prescribed in combination with aspirin;

2. For requests in conditions a, b, and c (above): Failure of Eliquis® used for $\geq$ 30 days at up to maximally indicated doses, unless both are contraindicated or clinically significant adverse effects are experienced;

3. Dose does not exceed maximum dose indicated in Section V.

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

A. All FDA-approved Indications (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 maximum dose indicated in Section V.

Approval duration: 12 months

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 CP.PMN.53 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 – CP.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

- CrCl: creatinine clearance
- DVT: deep venous thrombosis
- FDA: Food and Drug Administration
- NVAF: non-valvular atrial fibrillation
- PE: pulmonary embolism
- VTE: venous thromboembolism

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.
### Appendix C: Contraindications/Boxed Warnings

- **Contraindication(s):**
  - Active pathological bleeding
  - Severe hypersensitivity reaction to Xarelto

- **Boxed warning(s):**
  - Premature discontinuation of Xarelto increases the risk of thrombotic events
  - Spinal/epidural hematoma may occur in patients treated with Xarelto who are receiving neuraxial anesthesia or undergoing spinal puncture

### V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>NVAF</td>
<td>15 mg or 20 mg PO QD</td>
<td>20 mg/day</td>
</tr>
<tr>
<td>Treatment of DVT and PE</td>
<td>15 mg PO BID for the first 21 days, followed by 20 mg PO QD for the remaining treatment</td>
<td>See dosing regimen</td>
</tr>
<tr>
<td>Reduction in the risk of recurrence of DVT and PE</td>
<td>10 mg PO QD</td>
<td>10 mg/day</td>
</tr>
<tr>
<td>Prophylaxis of DVT and PE following hip replacement surgery</td>
<td>10 mg PO QD</td>
<td>10 mg/day</td>
</tr>
<tr>
<td>Prophylaxis of vte in acutely ill medical patients at risk for thromboembolic complications not at high risk of bleeding</td>
<td>10 mg PO QD in hospital and after discharge for a total recommended duration of 31 to 39 days</td>
<td>10 mg/day</td>
</tr>
</tbody>
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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.
### Indication

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary artery disease or peripheral artery disease</td>
<td>2.5 mg PO BID in combination with aspirin 75-100 mg PO QD</td>
<td>5 mg/day</td>
</tr>
</tbody>
</table>

### VI. Product Availability

Tablet: 2.5 mg, 10 mg, 15 mg, 20 mg

### VII. References


### Reviews, Revisions, and Approvals

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy created based on July SDC decision and prior clinical guidance.</td>
<td>07.20.20</td>
<td>08.20</td>
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</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.

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.

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**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.

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