BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

SAVAYSA™ (edoxaban tosylate) oral
Generic Equivalent (if available)

This Pharmacy Coverage Guideline (PCG):
- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively "Service") is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider's judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member's benefit plan; and
- Is subject to change as new information becomes available.

Scope
- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance
- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The "Criteria" section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member's benefit plan.
- The "Description" section describes the Service.
- The "Definition" section defines certain words, terms or items within the policy and may include tables and charts.
- The "Resources" section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the request form and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Criteria:

➢ **Criteria for initial therapy:** Savaysa (edoxaban tosylate) and/or generic equivalent (if available) is considered ***medically necessary*** and will be approved when **ALL** the following criteria are met:

1. Individual is 18 years of age or older

2. Individual has a confirmed diagnosis of **ONE** of the following:
   a. Non-valvular atrial fibrillation (NVAF)

   b. Deep vein thrombosis (DVT) and pulmonary embolism (PE) following 5-10 days of initial therapy with a parenteral anticoagulant

3. Individual has documented failure, contraindication per FDA label, intolerance, or is not a candidate for **BOTH** of the following:
    a. Eliquis (apixaban)
    b. Xarelto (rivaroxaban)

4. **If available**: Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

5. Creatinine clearance (CrCl) between 15-95 mL/minute

6. Individual does not have **ANY** of the following:
    a. Mechanical heart valve
    b. Moderate to severe mitral stenosis
    c. Triple positive antiphospholipid syndrome (positive for lupus anticoagulant, anticardiolipin antibodies, and anti-beta 2-glycoprotein I antibodies)
    d. Moderate to severe hepatic impairment (Child-Pugh Class B and C)

7. There are **NO** FDA-label contraindications such as active pathological bleeding

8. There are no significant interacting drugs such as:
    a. Anticoagulants (e.g., heparin, enoxaparin, others)
    b. Antiplatelets (e.g., aspirin, ibuprofen, naproxen, others)
    c. Thrombolytics (e.g., alteplase, reteplase, others)
    d. Selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, sertraline, others)
    e. Serotonin norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine, others)
    f. Rifampin

Initial approval duration:
- For NVAF: 12 months
- For DVT and PE: 6 months

➢ **Criteria for continuation of coverage (renewal request):** Savaysa (edoxaban tosylate) and/or generic equivalent (if available) is considered ***medically necessary*** and will be approved when **ALL** the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Individual's condition has responded while on therapy with response defined as **ONE** of the following:
    a. No embolic events in last 12 months for NVAF
    b. No embolic events in last 6 months for DVT/PE

2. Individual has been adherent with the medication

3. **If available**: Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

4. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use as follows:
    a. Contraindications as listed in the criteria for initial therapy section
    b. Significant adverse effect such as severe bleeding

5. There are no significant interacting drugs such as:
    a. Anticoagulants (e.g., heparin, enoxaparin, others)
    b. Antiplatelets (e.g., aspirin, ibuprofen, naproxen, others),
    c. Thrombolytics (e.g., alteplase, reteplase, others)
    d. Selective serotonin reuptake inhibitors (e.g., citalopram, fluoxetine, sertraline, others)
    e. Serotonin norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine, others)
    f. Rifampin

Renewal duration:
- For NVAF: 12 months
- For DVT and PE: 6 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**

2. **Off-Label Use of Cancer Medications**

Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting
MedWatch Forms for FDA Safety Reporting | FDA

Resources:

Savaysa (edoxaban tosylate) product information, revised by Daiichi Sankyo, Inc. 10 2023. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed July 17, 2024.

Lip GYH, Hull RD, Garcia DA. Selecting adult patients with lower extremity deep venous thrombosis and pulmonary embolism for indefinite anticoagulation. In: UpToDate, Mandel J, Douketis JD, Finley G (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through June 2024. Topic last updated January 25, 2024. Accessed July 17, 2024.

Manning WJ, Singer DE, Lip GYH. Atrial fibrillation in adults: Selection of candidates for anticoagulation. In: UpToDate, Zimetbaum PJ, Kasner SE, Knight BP, Yeon SB (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through June 2024. Topic last updated January 11, 2024. Accessed July 17, 2024.

Manning WJ, Singer DE, Lip GYH. Atrial fibrillation in adults: Use of oral anticoagulants. In: UpToDate, Zimetbaum PJ, Kasner SE, Knight BP, Yeon SB (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through June 2023. Topic last updated March 08, 2024. Accessed July 17, 2024.

Ortel TL, Neumann I, Ageno W, et al.: American Society of Hematology 2020 guidelines for management of venous thromboembolism: treatment of deep vein thrombosis and pulmonary embolism. Blood Advances 2020 Oct 13;4(19): 4693-4738. Accessed July 18, 2024.

Stevens SM, Woller SC, Kreuziger LB, et al.: Executive Summary: Antithrombotic Therapy for VTE Disease: Second Update of the CHEST Guideline and Expert Panel Report. CHEST 2021 Dec; 160(6):2247-2259. Accessed July 18, 2024.