Clinical Policy: Clonidine/Guanfacine

Reference Number: IN.CP.PMN.04
Effective Date: 10.19
Last Review Date: 10.20
Line of Business: Medicaid

Revision Log

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

Description

To promote prudent prescribing of alpha$_2$-adrenergic agonists.
Duplicate alpha$_2$-adrenergic agonist therapy is characterized as claims for two different chemical entities.
The following concurrent uses will be allowed:

- Clonidine ER product with a clonidine IR product
- Guanfacine ER product with a guanfacine IR product

FDA Approved Indication(s)

Edits are based on FDA labeling as published by the manufacturer

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.

If request is for Clonidine/Guanfacine, see approval criteria below:

I. Initial Approval Criteria

A. Attention Deficit Hyperactivity Disorder (must meet all)**:**

1. Diagnosis of ADHD;
2. Systolic Blood Pressure > 100;
3. Prescriber has provided rationale as to why the same chemical entity (i.e., clonidine ER with clonidine IR, guanfacine IR with guanfacine ER) cannot be used throught the day rather than duplicating therapy with two alpha2-adrengergic agonist.

Approval duration: 6 months

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.PMN.53 for Medicaid.

II. Continued Therapy (must meet all)

A. There is a history of paid claims for the requested alpha2-adrenergic agonist (i.e., clonidine or guanfacine) for 90 days of the past 120 days.

B. The patient has a previous authorization on file for the requested alpha2-adrenergic agonist (i.e., clonidine or guanfacine).

Approval duration: 6 months

REFERENCES:
Manufacturers' published FDA recommendations
MHS Preferred Drug List (PDL)

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy Created	10/2019	10/2019
Annual Review	10/20	10/14/20

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.