Clinical Policy: Roflumilast (Daliresp, Zoryve)

Reference Number: DE.PMN.46
Effective Date: 01.23
Last Review Date: 01.23
Line of Business: Medicaid

Revision Log

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

Description
Roflumilast (Daliresp®, Zoryve™) is a selective phosphodiesterase 4 inhibitor.

FDA Approved Indication(s)
Daliresp is indicated as a treatment to reduce the risk of chronic obstructive pulmonary disease (COPD) exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations.

Zoryve is indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 12 years of age and older.

Limitation(s) of use:
- Daliresp is not a bronchodilator and is not indicated for the relief of acute bronchospasm.
- Daliresp 250 mcg is a starting dose for the first 4 weeks of treatment only and is not the effective (therapeutic) dose.

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 Daliresp and Zoryve are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Chronic Obstructive Pulmonary Disease (must meet all)**:**

1. Request is for roflumilast tablet (Daliresp);
2. Diagnosis of COPD;
3. Age ≥ 18 years;
4. Current (within the past 30 days) forced expiratory volume in one second (FEV_1) < 50% predicted;
5. Failure of an adequate trial of at least two preferred* FDA-approved drugs for the indication and/or drugs that are considered the standard of care within the same drug class on the PDL, when such agents exist, at maximum indicated doses, unless clinically significant adverse effect are experienced, or all are contraindicated;
   **Generic is preferred, if available, and brand is not the preferred agent*
6. Daliresp is prescribed concurrently with a long-acting bronchodilator (i.e., LABA or LAMA);

7. Dose does not exceed both of the following (a and b):
   a. 500 mcg per day;
   b. 1 tablet per day.

Approval duration: 12 months

B. Plaque Psoriasis (must meet all)**:**
1. Request is for roflumilast cream (Zoryve);
2. Diagnosis of plaque psoriasis with body surface area involvement ≤ 20%;
3. Prescribed by or in consultation with a dermatologist or rheumatologist;
4. Age ≥ 12 years;
5. Member meets one of the following (a or b):
   a. Failure of both (i and ii) used concurrently, unless clinically significant adverse effects are experienced or all are contraindicated:
      i. Medium to ultra-high potency topical corticosteroid (*see Appendix B)*;
      ii. Calcipotriene, calcitriol, or tazarotene;
   b. For face or intertriginous areas (e.g., genitals, armpits, forearms, and groin): Failure of a topical calcineurin inhibitor* (*see Appendix B),* unless contraindicated or clinically adverse effects are experienced;
      **Prior authorization may be required for topical calcineurin inhibitors*
6. Request does not exceed 1 tube per month.

Approval duration: 12 months

C. 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.PMN.53.

II. Continued Therapy

A. Chronic Obstructive Pulmonary Disease (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Request is for roflumilast tablet (Daliresp);
3. Member is responding positively to therapy;
4. If request is for a dose increase, new dose does not exceed both of the following (a and b):
   a. 500 mcg per day;
   b. 1 tablet per day.

Approval duration: 12 months

B. Plaque Psoriasis (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Request is for roflumilast cream (Zoryve);
3. Member is responding positively to therapy;
4. If request is for a dose increase, new dose does not exceed 1 tube per month.

Approval duration: 12 months

C. 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.PMN.53.

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.PMN.53 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

COPD: chronic obstructive pulmonary disease
FDA: Food and Drug Administration
FEV_1: forced expiratory volume in one second
ICS: inhaled corticosteroid
LABA: long-acting $beta_2$-agonist
LAMA: long-acting antimuscarinic antagonist

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.

COPD		
Drug Name	**Dosing Regimen**	**Dose Limit/ Maximum Dose**
ICS/LABA Combinations		
fluticasone/salmeterol (Advair Diskus®)	Refer to prescribing information	Refer to prescribing information
Breo Ellipta® (fluticasone/ vilanterol)		
budesonide/formoterol (Symbicort®)		
Dulera®* (mometasone/ formoterol)	Doses of 10 mcg formoterol/400 mcg mometasone and 10 mcg formoterol/ 200 mcg mometasone, each inhaled BID, have been studied	The optimal dose has not been established
LABA/LAMA Combinations		
Bevespi Aerosphere® (formoterol/glycopyrrolate)	Refer to prescribing information	Refer to prescribing information
Utibron Neohaler® (indacaterol/glycopyrrolate)		

COPD		
Drug Name	**Dosing Regimen**	**Dose Limit/ Maximum Dose**
Anoro Ellipta® (vilanterol/umeclidinium)		
Stiolto Respimat® (olodaterol/tiotropium)		
LAMAs		
Tudorza Pressair® (aclidinium bromide)	Refer to prescribing information	Refer to prescribing information
Seebri Neohaler® (glycopyrrolate)		
Spiriva Respimat®/ HandiHaler® (tiotropium)		
Incruse Ellipta (umeclidinium)		
LABAs		
Brovana® (arformoterol)	Refer to prescribing information	Refer to prescribing information
Arcapta Neohaler® (indacaterol)		
Striverdi Respimat® (olodaterol)		
Serevent Diskus® (salmeterol)		
ICS/LABA/LAMA Combinations		
Trelegy™ Ellipta® (fluticasone/umeclidinium/ vilanterol)	1 inhalation by mouth QD	1 inhalation/day
Plaque Psoriasis		
Drug Name	**Dosing Regimen**	**Dose Limit/ Maximum Dose**
calcipotriene (Dovonex®) cream, ointment, solution	Apply topically to the affected area(s) BID	100 g/week
calcitriol (Vectical™) ointment	Apply topically to the affected area(s) BID	200 g/week
tazarotene (Tazorac®) gel, cream	Apply topically to the affected area(s) QHS	Once daily application
Ultra-High Potency Topical Corticosteroids		
augmented betamethasone dipropionate 0.05% (Diprolene®, Alphatrex®) ointment, gel	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
clobetasol propionate 0.05% (Temovate®, Temovate E®)		

Plaque Psoriasis		
Drug Name	**Dosing Regimen**	**Dose Limit/ Maximum Dose**
cream, ointment, gel, solution		
diflorasone diacetate 0.05% (Apexicon®) ointment		
halobetasol propionate 0.05% (Ultravate®) cream, ointment		
High Potency Topical Corticosteroids		
augmented betamethasone dipropionate 0.05% (Diprolone®, Diprolene® AF) cream, lotion	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
betamethasone dipropionate 0.05% ointment		
desoximetasone (Topicort®) 0.25%, 0.05% cream, ointment, gel		
diflorasone 0.05% (Apexicon E®) cream		
fluocinonide acetonide 0.05% cream, ointment, gel, solution		
triamcinolone acetonide 0.5% (Aristocort®, Kenalog®) cream, ointment		
Medium/Medium to High Potency Topical Corticosteroids		
betamethasone dipropionate 0.05% cream	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
desoximetasone 0.05% (Topicort®) cream, ointment, gel		
fluocinolone acetonide 0.025% (Synalar®) cream, ointment		
fluticasone propionate 0.05% (Cutivate®) cream		
mometasone furoate 0.1% (Elocon®) cream, lotion, ointment		

Plaque Psoriasis		
Drug Name	**Dosing Regimen**	**Dose Limit/ Maximum Dose**
triamcinolone acetonide 0.1%, 0.25%,0.5% (Aristocort®, Kenalog®) cream, ointment		
Combination Corticosteroid + (Vitamin D Analog or Retinoid)		
Enstilar® (calcipotriene 0.005% and betamethasone dipropionate 0.064%) foam	Apply topically to affected areas QD for up to 4 weeks. Avoid use on face, groin, axillae, skin treatment site with atrophy present, or with occlusive dressing unless directed by a healthcare provider	60 g/4 days
Duobrii® (halobetasol propionate 0.01% and tazarotene 0.045%) lotion	Apply a thin layer of lotion once daily to affected areas until control is achieved	50 g/week
Topical Calcineurin Inhibitors		
tacrolimus (Protopic®) **(off-label)**	Apply twice daily to psoriatic lesions of the face and intertriginous areas	2 applications/day
pimecrolimus (Elidel®) **(off-label)**	Apply twice daily to affected intertriginous areas	2 applications/day

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.
**Off-label*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): moderate to severe liver impairment (Child-Pugh B or C)
- Boxed warning(s): none reported

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Daliresp	COPD	500 mcg PO QD (starting treatment with 250 mcg QD for 4 weeks and increasing to 500 mcg QD thereafter may reduce the rate of discontinuation in some patients)	500 mcg/day
Zoryve	Plaque psoriasis	Apply cream to affected areas once daily	Once daily application

VI. Product Availability

Drug Name	Availability
Daliresp	Tablets: 250 mcg, 500 mcg
Zoryve	Cream (0.3%): 60 g tube

VII. References

1. Daliresp Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals; March 2020. Available at: https://www.daliresp.com/. Accessed March 30, 2022.
2. Zoryve Prescribing Information. Westlake Village, CA: Arcutis Biotherapeutics, Inc; July 2022. Available at https://www.zoryvehcp.com/. Accessed August 5, 2022.
3. Global Initiative for Chronic Obstructive Lung Disease (GOLD): Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease (2022 report). Available from: http://www.goldcopd.org/. Accessed March 30, 2022.
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2022. Available at: http://www.clinicalpharmacology-ip.com/. Accessed March 30, 2022.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	11.22	01.23

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.

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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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