Clinical Policy: Tobramycin (Bethkis Inhalation Solution, Kitabis Pak, TOBI Inhalation Solution, TOBI Podhaler)

Reference Number: CP.PHAR.211
Effective Date: 05/16
Last Review Date: 05/17

Coding Implications
Revision Log

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

Description

The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for tobramycin inhalation solution with nebulizer (Kitabis™ Pak/authorized generic Tobramycin Inhalation Solution Pak), tobramycin inhalation solution (Bethkis®, TOBI®/generic), and tobramycin inhalation powder (TOBI® Podhaler™).

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that tobramycin inhalation solution and TOBI Podhaler are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cystic Fibrosis (must meet all):

1. Age ≥ 6 years;
2. Diagnosis of cystic fibrosis (CF);
3. Pseudomonas aeruginosa is present in at least one culture of the airways;
4. Therapeutic plan does NOT include concurrent or alternating use of Cayston (aztreonam inhalation solution) with tobramycin for inhalation;
5. Prescribed total daily dose does not exceed 600 mg (tobramycin inhalation solution) or 224 mg (TOBI Podhaler), each administered on a 28 days on/28 days off cycle;
6. FEV_1 is ≥ 25% to ≤ 90% predicted (≥ 40% to ≤ 90% predicted if request is for Bethkis).

Approval duration: 6 months

B. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.

II. Continued Approval

A. Cystic Fibrosis (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
2. Member is responding positively to therapy (e.g.: stable or improved pulmonary function, improved quality of life, reduced hospitalization);
3. Therapeutic plan does NOT include concurrent or alternating use of Cayston (aztreonam inhalation solution) with tobramycin for inhalation;
4. Prescribed total daily dose does not exceed 600 mg (tobramycin inhalation solution) or 224 mg (TOBI Podhaler), each administered on a 28 days on/28 days off cycle.

Approval duration: 12 months

B. Other diagnoses/indications (1 or 2)**:**
1. Currently, receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to CP.PHAR.57 - Global Biopharm Policy.

Background
Description/Mechanism of Action:
Tobramycin is an aminoglycoside antimicrobial produced by Streptomyces tenebrarius. It acts primarily by disrupting protein synthesis leading to altered cell membrane permeability, progressive disruption of the cell envelope, and eventual cell death. When inhaled, tobramycin is concentrated in the airways.

Formulations:
Nebulization solution for inhalation
- Tobramycin (preservative free)
  - Bethkis: 300 mg tobramycin/4 mL (4 mL) (limited distribution)
  - Kitabis Pak: 300 mg tobramycin/5 mL (5 mL) (with reusable PARI LC Plus nebulizer)
    - Authorized generic available: Tobramycin Inhalation Solution Pak (with reusable PARI LC Plus nebulizer)
  - TOBI: 300 mg tobramycin/5mL (5 mL)
    - Generic available

Powder for inhalation (capsules and device)
- TOBI Podhaler: 28 mg tobramycin per capsule

FDA Approved Indications:
TOBI/generic, TOBI Podhaler, Kitabis Pak/generic are indicated for:
- Management of CF patients with Pseudomonas aeruginosa.

Limitations of use:
- Safety and efficacy have not been demonstrated in patients under the age of 6 years, patients with forced expiratory volume in 1 second (FEV_1) <25% (Bethkis <40%) or >80% predicted, or patients colonized with Burkholderia cepacia.

Appendices
Appendix A: Abbreviation Key
CF: cystic fibrosis
FEV_1: forced expiratory volume in one second

Coding Implications
Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J7682	Tobramycin, inhalation solution, FDA-approved final product, noncompounded, unit dose form, administered through DME, per 300 mg
J7685	Tobramycin, inhalation solution, compounded product, administered through DME, unit dose form, per 300 mg

Reviews, Revisions, and Approvals	Date	Approval Date
Policy split from CP.PHAR.54 CF Treatments. Concurrent use of Cayston with TOBI/TOBI Podhaler is restricted per 2015 expert review citing lack of evidence. Appendix C (clinical reasons to continue CF therapy) is replaced by "Member continues to respond positively to TOBI/TOBI Podhaler therapy in one or more of the following areas: pulmonary function, quality of life, pulmonary exacerbations." Approval periods are extended from 3 to 6 and 6 to 12 months. Added Kitabis Pak.	05/16	05/16
Bethkis added (limited distribution – see references for distribution network). Kitabis authorized generic added. FEV1 delineation of ≤90% added to initial criteria. Allergy contraindication removed. Efficacy statement edited to indicate a general positive response to therapy.	05/17	05/17

References

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2. Kitabis Pak Prescribing Information. Woodstock, IL: Catalent Pharm Solutions, LLC; November 2014. Available at http://kitabis.com/wp-content/uploads/pdfs/Kitabis-Pak-Full-Prescribing-Information.pdf. Accessed May 1, 2017.
3. Tobramycin Inhalation Solution Pak Prescribing Information. Woodstock, IL: Catalent Pharma Solutions, LLC; May 2016. Available at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=dad13445-f591-4829-96f9-1598ba03dff8. Accessed May 1, 2017.
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5. TOBI Podhaler Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation; October 2015. Available at https://www.pharma.us.novartis.com/sites/www.pharma.us.novartis.com/files/tobipodhaler.pdf. Accessed May 1, 2017.
6. Flume PA, Mogayzel PJ, Robinson KA, et al. Cystic fibrosis pulmonary guidelines. Treatment of pulmonary exacerbations. *Am J Respir Crit Care Med.* 2009; 180: 802-808.

7. Mogayzel PJ, Naureckas ET, Robinson KA, et al. Cystic fibrosis pulmonary guidelines: Chronic medications for maintenance of lung health. *Am J Respir Crit Care Med.* April 1, 2013; 187 (7): 680-689.

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.

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.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.