

Clinical Policy: Vorapaxar (Zontivity)

Reference Number: HIM.PA.146

Effective Date: 10.31.17

Last Review Date: 02.25

Line of Business: HIM

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Vorapaxar (Zontivity[®]) is a protease-activated receptor-1 antagonist.

FDA Approved Indication(s)

Zontivity is indicated for the reduction of thrombotic cardiovascular events in patients with a history of myocardial infarction (MI) or with peripheral arterial disease (PAD). Zontivity has been shown to reduce the rate of a combined endpoint of cardiovascular death, MI, stroke, and urgent coronary revascularization (UCR).

Policy/Criteria

Provider must submit documentation (including 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 Zontivity is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Cardiovascular Event Prophylaxis (must meet all):

1. Member has history of MI and/or diagnosis of PAD;
2. Prescribed by or in consultation with a cardiologist;
3. Zontivity is prescribed in combination with at least one of the following (a or b):
 - a. aspirin (*generic preferred*);
 - b. clopidogrel (*generic preferred*);
4. Dose does not exceed both of the following (a and b):
 - a. 2.08 mg per day;
 - b. 1 tablet per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or

- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. Cardiovascular Event Prophylaxis (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed both of the following (a and b):
 - a. 2.08 mg per day;
 - b. 1 tablet per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: HIM.PA.33 for health insurance marketplace; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: HIM.PA.103 for health insurance marketplace; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: HIM.PA.154 for health insurance marketplace.

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 – HIM.PA.154 for health insurance marketplace or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration

MI: myocardial infarction
PAD: peripheral arterial disease
UCR: urgent coronary revascularization

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
clopidogrel (Plavix [®])	75 mg PO QD	75 mg/day
aspirin	75 to 100 mg PO QD	100 mg/day

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - History of stroke, transient ischemic attack, or intracranial hemorrhage
 - Active pathologic bleeding
- Boxed warning(s): bleeding risk; do not use Zontivity in patients with history of stroke, TIA, or intracranial hemorrhage or active pathologic bleeding.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Cardiovascular event prophylaxis	2.08 mg (1 tablet) PO QD	2.08 mg/day

VI. Product Availability

Tablet: 2.08 mg

VII. References

1. Zontivity Prescribing Information. Whitehouse Station, NJ: Merck Sharp & Dohme Corp. October 2022. Available at: www.zontivityhcp.com. Accessed November 8, 2024.
2. Gornik HL, Aronow HD, Goodney PP, et al. 2024 ACC/AHA/AACVPR/APMA/ABC/SCAI/SVM/SVN/SVS/SIR/VESS Guideline for the Management of Lower Extremity Peripheral Artery Disease: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation*. 2024 Jun 11;149(24):e1313-e1410. doi: 10.1161/CIR.0000000000001251.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	11.30.20	02.21
1Q 2022 annual review: no significant changes; references reviewed and updated.	11.23.21	02.22

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Template changes applied to other diagnoses/indications and continued therapy section.	10.11.22	
1Q 2023 annual review: no significant changes; references reviewed and updated.	10.12.22	02.23
1Q 2024 annual review: clarified generic products is preferred for aspirin and clopidogrel; references reviewed and updated.	11.16.23	02.24
1Q 2025 annual review: no significant changes; references reviewed and updated.	11.08.24	02.25

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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