PRIOR AUTHORIZATION POLICY

POLICY: Anticoagulants – Eliquis Prior Authorization Policy
- Eliquis® (apixaban tablets – Bristol-Myers Squibb/Pfizer)

REVIEW DATE: 01/11/2023

OVERVIEW

Eliquis, a Factor Xa inhibitor, is indicated for the following uses:[1]
- **Non-valvular atrial fibrillation**, to reduce the risk of stroke and systemic embolism.
- **Prophylaxis of deep vein thrombosis (DVT)**, which may lead to pulmonary embolism (PE), in patients who have undergone hip or knee replacement surgery.
- **Treatment of DVT and PE**, as well as **reduction in the risk of recurrence of DVT and PE** following initial therapy.

Safety and effectiveness of Eliquis in pediatric patients have not been established.[1]

Guidelines

Guidelines are available which support the use of direct oral anticoagulants (DOACs) in their commonly used clinical settings, such as DVT/PE[2-5] and atrial fibrillation[6,7]. In patients who are eligible for a DOAC, these are generally preferred over vitamin K antagonists (e.g., warfarin). It is noted that in the randomized trials in atrial fibrillation, DOACs were consistently at least non-inferior to warfarin regarding the composite of stroke or systemic embolism and were associated with lower risk of serious bleeding.[7]

Anticoagulants and Coronavirus Disease 19 (COVID-19)

Several clinical practice guidelines have been published with regard to use of anticoagulant therapy in the management of COVID-19. Per National Institutes of Health treatment guidelines regarding antithrombotic therapy in patients with COVID-19 (updated December 28, 2022), hospitalized patients with COVID-19 should not be routinely discharged from the hospital while on venous thromboembolism (VTE) prophylaxis.[8] For patients at low risk for bleeding and high risk for VTE, continuing anticoagulation with an FDA-approved regimen for extended VTE prophylaxis may be considered, as per protocols for patients without COVID-19. Of note, Xarelto® (rivaroxaban tablets and oral suspension) is FDA-approved for prophylaxis of VTE in acutely ill medical patients; Eliquis is not indicated in this setting. Other guidelines have similar recommendations.[9-11]

Other Uses with Supportive Evidence

Although data are not robust regarding use of DOACs in off-label thromboembolic-related conditions, CHEST guidelines (2012) suggest anticoagulation for certain patients with superficial vein thrombosis, symptomatic splanchnic thromboses (portal, mesenteric, and/or splenic vein), or symptomatic hepatic vein thrombosis.[2] The guidelines acknowledge the limited available data in these settings, and all are given Grade 2C recommendations (weak recommendation, low-quality evidence). The 2016 CHEST guideline update did not address these conditions or comment on the role of DOACs.[3] The choice of anticoagulant is often individualized based on patient-specific factors; therefore, for certain patients, DOAC use may be considered in practice. Evidence for DOACs is limited for off-label scenarios; in general, agents such as vitamin K antagonists (e.g., warfarin) and low molecular weight heparin have more clinical experience in these settings.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Eliquis. All approvals are provided for the duration noted below. In cases where the approval is authorized in months, 1 month is equal to 30 days.

Automation: None.

RECOMMENDED AUTHORIZATION CRITERIA

Coverage of Eliquis is recommended in those who meet one of the following criteria:

FDA-Approved Indications

1. **Atrial Fibrillation (or Atrial Flutter).** Approve for 1 year if the patient is ≥ 18 years of age.

2. **Deep Vein Thrombosis in a Patient Undergoing Hip or Knee Replacement Surgery, Prophylaxis.** Approve for 60 days if the patient is ≥ 18 years of age.

3. **Deep Vein Thrombosis or Pulmonary Embolism, Treatment.** Approve for 1 year if the patient is ≥ 18 years of age.

4. **Deep Vein Thrombosis or Pulmonary Embolism to Reduce the Risk of Recurrence.** Approve for 1 year if the patient is ≥ 18 years of age.

Other Uses with Supportive Evidence

5. **Treatment or Prevention of Other Thromboembolic-Related Conditions.** Approve for 6 months if the patient meets both of the following criteria (A and B):
   Note: Examples of other thromboembolic-related conditions include superficial vein thrombosis, splanchnic vein thrombosis, hepatic vein thrombosis, or prophylaxis of venous thromboembolism in a high-risk patient.
   A) Patient is ≥ 18 years of age; AND
   B) Patient meets one of the following (i or ii):
      i. Patient has tried warfarin, fondaparinux injection, or a low molecular weight heparin product (e.g., enoxaparin injection, Fragmin [dalteparin injection]); OR
      Note: A patient who has tried Xarelto (rivaroxaban tablets), Pradaxa (dabigatran capsules), or Savaysa (edoxaban tablets) is not required to try warfarin, fondaparinux, or a low molecular weight heparin product.
      ii. Patient has been started on Eliquis for the treatment of an acute thromboembolic condition.

CONDITIONS NOT RECOMMENDED FOR APPROVAL

Coverage of Eliquis is not recommended in the following situations:

1. **Venous Thromboembolism in an Acutely Ill Medical Patient, Prophylaxis.** (Note: This includes post-discharge thromboprophylaxis for a patient hospitalized with coronavirus disease 19 [COVID-19]). Eliquis has been compared with enoxaparin for post-discharge prophylaxis in acutely ill medical patients; however, superiority vs. enoxaparin was not achieved, and bleeding was increased with Eliquis.[12] Xarelto is labeled for prophylaxis of venous thromboembolism in acutely ill medical patients

and is supported in clinical practice guidelines, including guidelines which address prophylaxis of venous thromboembolism in COVID-19 patients.[8-11]

2. Coverage is not recommended for circumstances not listed in the Recommended Authorization Criteria. Criteria will be updated as new published data are available.

REFERENCES

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12. Goldhaber SZ, Leizorovicz A, Kakkar AK, et al. Apixaban versus enoxaparin for thromboprophylaxis in medically ill patients. *N Engl J Med*. 2011 Dec 8;365(23):2167-77.