CENTENE Corporation

Clinical Policy: Uridine triacetate (Vistogard)

Reference Number: HIM.PA.SP55
Effective Date: 12.01.17
Last Review Date: 11.19
Line of Business: HIM

Revision Log

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

Description
Uridine acetate (Vistogard®) is a pyrimidine analog.

FDA Approved Indication(s)
Vistogard is indicated for the emergency treatment of adult and pediatric patients:
- Following a fluorouracil or capecitabine overdose regardless of the presence of symptoms, or
- Who exhibit early-onset, severe or life-threatening toxicity affecting the cardiac or central nervous system, and/or early onset, unusually severe adverse reactions (e.g., gastrointestinal toxicity and/or neutropenia) within 96 hours following the end of fluorouracil or capecitabine administration.

Limitation(s) of use:
- Vistogard is not recommended for the non-emergent treatment of adverse reactions associated with fluorouracil or capecitabine because it may diminish the efficacy of these drugs.
- The safety and efficacy of Vistogard initiated more than 96 hours following the end of fluorouracil or capecitabine administration have not been established.

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 Vistogard is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Fluorouracil or Capecitabine Overdose or Toxicity (must meet all)**:**
1. Prescribed for the management of overdose or toxicity due to fluorouracil or capecitabine administration;
2. Request is within 96 hours of the last administered dose of fluorouracil or capecitabine;
3. Dose does not exceed 40 g per day (4 packets per day).

Approval duration: 1 month (Up to 20 doses)
**Total therapy should not exceed 20 doses*

B. 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): HIM.PHAR.21.

II. Continued Therapy

A. Fluorouracil or Capecitabine Overdose or Toxicity (must meet all)**:**
1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member has not received ≥ 20 doses;
3. If request is for a dose increase, new dose does not exceed 40 g per day (4 packets per day).

Approval duration: 1 month (Up to 20 doses)
**Total therapy should not exceed 20 doses*

B. 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 3 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): HIM.PHAR.21.

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 policy – HIM.PHAR.21 or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Fluorouracil or capecitabine overdose or toxicity	Adults: 10 g (1 packet) PO Q6H for 20 doses	10 g/dose (for up to 20 doses)

Indication	Dosing Regimen	Maximum Dose
	Pediatrics: 6.2 g/m^2 of body surface area PO Q6H for 20 doses	

VI. Product Availability

Oral granules: 10 g per single-dose packet

VII. References

1. Vistogard Prescribing Information. Rockville, MD: Wellstat Therapeutics Corporation; February 2017. Available at: www.vistogard.com. Accessed August 18, 2019

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	09.01.17	11.17
4Q 2018 annual review: no significant changes; references reviewed and updated.	08.14.18	11.18
4Q 2019 annual review: no significant changes; references reviewed and updated.	08.10.19	11.19

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 Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.

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