



Horizon BCBSNJ
Medical Necessity Guideline

Section Drugs
Policy Number
Effective Date 10/7/06
Review Date 2/29/08, 3/10/09

Subject:

BRAND NAME
(Generic)

BYETTA
(exenatide)

IMPORTANT NOTE:

*The purpose of this policy is to provide general information applicable to the administration of outpatient prescription drug benefits that Horizon Blue Cross Blue Shield of New Jersey and Horizon Healthcare of New Jersey, Inc. (collectively "Horizon BCBSNJ") insures or administers. **Outpatient prescription drugs are not covered under all Horizon benefit plans.** If the member's contract benefits differ from the pharmacy guideline, the contract prevails. Although a service, supply drug or procedure may be medically necessary, it may be subject to limitations and/or exclusions under a member's benefit plan. If a service, supply drug or procedure is not covered and the member proceeds to obtain the service, supply drug or procedure, the member may be responsible for the cost. Decisions regarding treatment and treatment plans are the responsibility of the physician. This policy is not intended to direct the course of clinical care a physician provides to a member, and it does not replace a physician's or pharmacist's independent professional clinical judgment or duty to exercise special knowledge and skill in the treatment of Horizon BCBSNJ members. Horizon BCBSNJ is not responsible for, does not provide, and does not hold itself out as a provider of medical care. The physician remains responsible for the quality and type of health care services provided to a Horizon BCBSNJ member.*

Horizon BCBSNJ pharmacy guidelines do not constitute medical advice, authorization, certification, approval, explanation of benefits, offer of coverage, contract or guarantee of payment.

FDA-APPROVED INDICATION

Byetta is indicated as adjunctive therapy to improve glycemic control in patients with type 2 diabetes mellitus who are taking metformin, a sulfonylurea, a thiazolidinedione, a combination of metformin and a sulfonylurea, or a combination of metformin and a thiazolidinedione, but have not achieved adequate glycemic control.

Initial Step Therapy:

If the patient has filled a prescription for one of the antidiabetic agents listed in Table 1 for at least a 30-day supply under a prescription benefit administered by Caremark in the previous 120 days, the requested step therapy drug will be paid under that prescription benefit for up to the maximum FDA-approved dosing (Table 2) to ensure appropriate use and to minimize adverse events.

If the patient does not meet the step therapy criteria, then the claim will reject with a message indicating that prior authorization is required. The pharmacy will also receive the following message: "use Byetta in combination with oral metformin or sulfonylurea agents". The prior authorization criteria would then be applied to requests submitted for evaluation by the PA unit.

Table 1

Required Drug	Dose
metformin	All strengths/forms
acetohexamide	All strengths/forms
chlorpropamide	All strengths/forms
tolazamide	All strengths/forms
tolbutamide	All strengths/forms
glipizide	All strengths/forms
glyburide (micronized and nonmicronized)	All strengths/forms
glimepiride	All strengths/forms
glyburide/metformin	All strengths/forms

glipizide/metformin	All strengths/forms
Actos	All strengths/forms
Avandia	All strengths/forms
insulin	All types/forms

Table 2

Strength	Number of Doses	Quantity
5 mcg per dose	60 doses	1.2 mL prefilled pen
10 mcg per dose	60 doses	2.4 mL prefilled pen

CRITERIA FOR APPROVAL

1. Is the patient \geq 18 years of age?	Yes	No
2. Does the patient have the diagnosis of type 2 diabetes mellitus?	Yes	No
3. Is the patient currently receiving insulin, metformin, sulfonylurea, or thiazolidinedione therapy? [Tech Only: examples of sulfonylureas may include: Amaryl, glipizide, glyburide, tolbutamide; examples of thiazolidinediones may include: Actos, Avandia]	Yes	No
4. Does the patient have severe renal impairment (creatinine clearance < 30 mL/min)?	Yes	No
5. Does the patient have severe gastrointestinal disease (e.g., gastroparesis)?	Yes	No
6. Does the dose prescribed require MORE THAN 1 prefilled pen (60 doses) per month?	Yes	No

Guidelines for Approval

Duration of Approval	12 months
Quantity for Approval	1 prefilled pen of 60 doses each per month 3 prefilled pens of 60 doses each per 3 months
Set 1	
Yes to question(s)	No to question(s)
1	4
2	5
3	6

Horizon BCBSNJ Pharmacy Guideline Development Process: This Horizon BCBSNJ Pharmacy Guideline (the "Pharmacy Guideline") has been developed by Horizon BCBSNJ's Pharmacy Drug Policy Subcommittee, Clinical Issues Subcommittee, and Quality Improvement Committee which include practicing physicians and pharmacists. This guideline is consistent with generally accepted standards of medical and pharmacy practice, and reflects Horizon BCBSNJ's view of the subject health care services, supplies drugs or procedures, and in what circumstances they are deemed to be medically necessary or experimental/ investigational in nature. This Pharmacy Guideline also considers whether and to what degree the subject health care services, supplies or procedures are clinically appropriate, in terms of type, frequency, extent, site and duration and if they are considered effective for the illnesses, injuries or diseases discussed. Where relevant, this Pharmacy Guideline considers whether the subject prescription drugs are being requested primarily for the convenience of the covered person or the health care provider. It may also consider whether the prescription drugs are more costly than alternative prescription drugs that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the relevant illness, injury or disease. In reaching its conclusion regarding what it considers to be the generally accepted standards of medical and pharmacy practice, Horizon BCBSNJ reviews and considers the following: all credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician and health care provider specialty society recommendations, the views of physicians

and health care providers practicing in relevant clinical areas (including, but not limited to, the prevailing opinion within the appropriate specialty), the findings and directives of the Food and Drug Administration and any other relevant factor as determined by applicable State and Federal laws and regulations.

RATIONALE

The intent of the criteria is to ensure that patients follow selection elements noted in labeling. Byetta is indicated as adjunctive therapy to improve glycemic control in patients with type 2 diabetes mellitus who are taking metformin, a sulfonylurea, or a combination of metformin and a sulfonylurea but have not achieved adequate glycemic control. Therapy with Byetta should be initiated at 5 mcg per dose administered twice daily at any time within the 60-minute period before the morning and evening meals. The dose of Byetta may be increased to 10 mcg twice daily after 1 month of therapy, if the patient's response is inadequate. Byetta is supplied as a sterile solution for subcutaneous injection containing 250 mcg/mL exenatide. Byetta is available in two dosages that contain 60 doses per prefilled syringe. The safety and efficacy of Byetta has not been studied in the pediatric population. Byetta is not recommended for use in patients with end-stage renal disease or severe renal impairment (creatinine clearance < 30 mL/min). Also, Byetta has not been studied in patients with severe gastrointestinal disease, including gastroparesis. Its use is commonly associated with gastrointestinal adverse effects, including nausea, vomiting, and diarrhea. Therefore, the use of Byetta is not recommended in patients with severe gastrointestinal disease.

Horizon-BCBSNJ has requested that the prior therapy requirements for the use of Byetta be automated. The patient must be taking insulin, metformin, a sulfonylurea agent, or a thiazolidinedione concurrently with Byetta. Therefore if the patient has filled any of these four antidiabetic agent within the previous 120 days, then Byetta will process through the prescription benefit without prior authorization. The automated step therapy will not take into consideration renal function or the existence of severe gastrointestinal disease. If the patient meets the step therapy requirements, then Byetta will be allowed to process for up to the maximum FDA-approved dosing. If the patient does not meet the automated step therapy requirements, a post-step prior authorization will be available.

REFERENCES

1. Byetta product information. Amylin Pharmaceuticals, Inc. October 2007.
2. John LE, Kan MP, Busch RS, et al. Expanded use of exenatide in the management of type 2 diabetes. *Diabetes Spectrum* 2007; 20: 59-63.
3. Viswanathan P, Chaudhuri A, Bhatia R, et al. Exenatide therapy in obese patients with type 2 diabetes mellitus treated with insulin. *Endocr Pract* 2007; 13: 444-450.
4. Oyer DS, Crawford RS, Shah A, et al. Exenatide in diabetic patients on insulin and TZDs [abstract]. *Diabetes* 2006, 55 (Suppl 1): A471-472. Abstract 2038-PO.
5. Bhatia R, Viswanathan P, Chaudhuri A, et al. Exenatide causes weight loss and a reduction in the insulin dose along with an improvement in HbA1c in obese type 2 diabetic on insulin [abstract]. *Diabetes* 2006; 55 (Suppl 1): A105. Abstract442-P.
6. Hood RC. Exenatide (EXE) use in T2DM with A1C ≤ 7% [abstract]. *Diabetes* 2006; 55 (Suppl 1): A116. Abstract 488-P.

Pharmacy Guidelines can be highly technical and are designed for use by the Horizon BCBSNJ professional staff in making coverage determinations. Members referring to this policy should discuss it with their treating physician or pharmacist, and should refer to their specific benefit plan for the terms, conditions, limitations and exclusions of their coverage.

This Horizon BCBSNJ Pharmacy Guideline is proprietary. It is to be used only as authorized by Horizon BCBSNJ and its affiliates. The contents of this Pharmacy Guideline are not to be copied, reproduced or circulated to other parties without the express written consent of Horizon BCBSNJ. The contents of this Pharmacy Guideline may be updated or changed without notice, unless otherwise required by law and/or regulation. However, benefit determinations are made in the context of Pharmacy Guidelines existing at the time of the decision and are not subject to later revision as the result of a change in Pharmacy Guideline.