



PRIOR AUTHORIZATION POLICY

- POLICY:** Anticoagulants – Savaysa Prior Authorization Policy
- Savaysa® (edoxaban tablets – Daiichi Sankyo)

REVIEW DATE: 01/24/2024

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. EACH COVERAGE REQUEST SHOULD BE REVIEWED ON ITS OWN MERITS. MEDICAL DIRECTORS ARE EXPECTED TO EXERCISE CLINICAL JUDGMENT AND HAVE DISCRETION IN MAKING INDIVIDUAL COVERAGE DETERMINATIONS. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Savaysa, a Factor Xa inhibitor, is indicated for the following uses:¹

- **Non-valvular atrial fibrillation**, to reduce the risk of stroke and systemic embolism.
- **Treatment of deep vein thrombosis (DVT) and pulmonary embolism (PE)**, following 5 to 10 days of initial therapy with a parenteral anticoagulant.

Savaysa has a unique Boxed Warning regarding reduced efficacy in non-valvular atrial fibrillation in patients with a creatinine clearance > 95 mL/min; Savaysa should be avoided in these individuals.¹ Safety and effectiveness of Savaysa in pediatric patients have not been established.

Guidelines

Guidelines are available which support the use of direct oral anticoagulants (DOACs) in their commonly used clinical settings, such as DVT/PE²⁻⁵ 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 2019 (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 October 10, 2023), hospitalized patients with COVID-19 should not be routinely discharged from the hospital while on venous thromboembolism (VTE) prophylaxis.⁸ For hospitalized patients, anticoagulant or antiplatelet therapy should not be used to prevent arterial thrombosis outside of the usual standard of care for patients without COVID-19. In nonhospitalized patients with COVID-19, it is not recommended to use anticoagulant and antiplatelet therapy for the prevention of VTE or arterial thrombosis, except in a clinical trials. 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

Savaysa has data for prophylaxis of VTE after hip replacement surgery.¹² Although data are not robust regarding use of DOACs in other off-label thromboembolic-related conditions, American College of Chest Physicians (CHEST) guidelines (2021) suggest anticoagulation for certain patients (e.g., superficial vein thrombosis, antiphospholipid syndrome).² 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, there is more clinical experience with agents such as vitamin K antagonists (e.g., warfarin) and low molecular weight heparin in these settings.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Savaysa. 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.

- **Savaysa[®] (edoxaban tablets (Daiichi Sankyo)**

is(are) covered as medically necessary when the following criteria is(are) met for FDA-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indications

- 1. Atrial Fibrillation (or Atrial Flutter).** Approve for 1 year if the patient meets both of the following (A and B):
 - A)** Patient is ≥ 18 years of age; AND
 - B)** Patient has an estimated creatinine clearance ≤ 95 mL/min.
- 2. Deep Vein Thrombosis or Pulmonary Embolism, Treatment.** Approve for 1 year if the patient is ≥ 18 years of age.

Other Uses with Supportive Evidence

3. Deep Vein Thrombosis in a Patient Undergoing Hip Replacement Surgery, Prophylaxis. Approve for 60 days if the patient is \geq 18 years of age.

4. Treatment or Prevention of Other Thromboembolic-Related Conditions.

Approve for 6 months if the patient meets both of the following (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 \geq 18 years of age; AND

B) Patient meets one of the following (i or ii):

i. Patient has tried warfarin, fondaparinux, or a low molecular weight heparin product (e.g., enoxaparin, Fragmin [dalteparin injection]); OR

Note: A patient who has tried Eliquis (apixaban tablets), Xarelto (rivaroxaban tablets and oral suspension), or Pradaxa (dabigatran capsules) is not required to try warfarin, fondaparinux, or a low molecular weight heparin.

ii. Patient has been started on Savaysa for the treatment of an acute thromboembolic condition.

CONDITIONS NOT COVERED

- **Savaysa[®] (edoxaban tablets (Daiichi Sankyo)**

is(are) considered experimental, investigational, or unproven for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. Venous Thromboembolism in an Acutely Ill Medical Patient, Prophylaxis.

(Note: This includes post-discharge thromboprophylaxis for a patient hospitalized with coronavirus disease 2019 [COVID-19]). 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.⁷⁻⁹

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. Raskob G, Cohen AT, Eriksson BI, et al. Oral direct factor Xa inhibition with edoxaban for thromboprophylaxis after elective total hip replacement. A randomized double-blind, dose-response study. *Thromb Haemost.* 2010;104(3):642-649.

HISTORY

Type of Revision	Summary of Changes	Review Date
Early Annual Revision	No criteria change.	01/11/2023
Annual Revision	No criteria change.	01/24/2024

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