PRIOR AUTHORIZATION POLICY

POLICY: Qbrexza Prior Authorization Policy
- Qbrexza™ (glycopyrronium cloth 2.4% for topical use – Journey Medical)

REVIEW DATE: 12/06/2023

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. 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

Qbrexza, an anticholinergic, is indicated for the topical treatment of **primary axillary** (i.e., underarm) **hyperhidrosis** in patients ≥ 9 years of age.[1] Qbrexza is applied topically once every 24 hours to clean dry skin on the underarm areas only; it is not for use on other body areas.

Guidelines

There are currently no guidelines for the treatment of hyperhidrosis published by a professional society. However, the International Hyperhidrosis Society, an independent, non-profit organization, provides an algorithm for the treatment of axillary hyperhidrosis (updated 2018).[2] Topical antiperspirant therapy or Qbrexza are both listed as initial treatment choices. It is noted in the algorithm that typically aluminum chloride hexahydrate 20% solution is the most commonly prescribed agent.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Qbrexza. All approvals are provided for the duration noted below.

- **Qbrexza™ (glycopyrronium cloth 2.4% for topical use – Journey Medical)**

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 Indication

1. **Hyperhidrosis, Primary Axillary.** Approve for 1 year if the patient meets the following (A, B, C, and D):
   - **A)** Patient is ≥ 9 years of age; AND
   - **B)** Hyperhidrosis is significantly interfering with the ability to perform age-appropriate activities of daily living; AND
   - **C)** The prescriber has excluded secondary causes of hyperhidrosis; AND
   - **D)** Patient meets one of the following (i or ii):
     - **i.** Patient has tried one prescription aluminum chloride-containing topical antiperspirant for at least 4 weeks and experienced inadequate efficacy; OR
     - **ii.** According to the prescriber, the patient has experienced significant intolerance with an aluminum-containing topical antiperspirant.

CONDITIONS NOT COVERED

- **Qbrexza™ (glycopyrronium cloth 2.4% for topical use – Journey Medical)**

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. **Hyperhidrosis, other than Primary Axillary.** Qbrexza is not intended for application to areas other than the axillae.[1]

REFERENCES

1. Qbrexza™ cloth [prescribing information]. Scottsdale, AZ: Journey Medical; October 2022.
2. International Hyperhidrosis Society. Primary axillary hyperhidrosis treatment algorithm. Updated September 23, 2018. Available at: https://sweathelp.org/treatments-hcp/clinical-guidelines/primary-focal-hyperhidrosis/primary-focal-axillary.html. Accessed on November 20, 2023.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	**Hyperhidrosis, Primary Axillary:** The following requirements were added: hyperhidrosis is significantly interfering with the ability to perform age-appropriate activities of daily living, and the prescriber has excluded secondary causes of hyperhidrosis. Additionally, regarding the existing requirement for a trial of an	12/07/2022

	aluminum-containing topical antiperspirant, this was revised such that the patient must meet one of the following: patient has tried one prescription aluminum-containing topical antiperspirant for at least 4 weeks and experienced inadequate efficacy; OR according to the prescriber, patient has experienced significant intolerance with an aluminum-containing topical antiperspirant.	
Annual Revision	No criteria changes.	12/06/2023