Drug Coverage Policy

Effective Date.....04/01/2024
Coverage Policy Number.....IP0074
Policy Title.....Qbrexza

Qbrexza

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

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.

Medical Necessity Criteria

Coverage criteria are listed for products **in below table(s):**

Employer Plans:

Product	Criteria
Qbrexza (glycopyrronium	**<u>Performance/Advantage/Total Savings Drug List Plans:</u>** **Qbrexza is considered medically necessary when the following criteria are met:**

Product	Criteria
cloth 2.4% for topical use)	1. **Hyperhidrosis, Primary Axillary.** Individual meets **ALL** of the following criteria: A. Age 9 years or older B. Condition is significantly interfering with the ability to perform age-appropriate activities of daily living C. Documentation of failure, contraindication or intolerance to at least **ONE** prescription aluminum chloride-containing topical antiperspirant (for example, Drysol) applied for at least 4 weeks. **<u>Standard/Value Drug List Plans:</u>** **Qbrexza is considered medically necessary when the following criteria are met:** 1. **Hyperhidrosis, Primary Axillary.** Individual meets the following criteria: A. Age 9 years or older

Individual and Family Plans:

Product	Criteria
Qbrexza (glycopyrronium cloth 2.4% for topical use)	**Qbrexza is considered medically necessary when the following criteria are met:** 1. **Hyperhidrosis, Primary Axillary.** Individual meets **ALL** of the following criteria: A. Age 9 years or older B. Condition is significantly interfering with the ability to perform age-appropriate activities of daily living C. Documentation of failure, contraindication or intolerance to at least **ONE** aluminum chloride-containing topical antiperspirant applied for at least 4 weeks.

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Reauthorization Criteria

Continuation of Qbrexza is considered medically necessary when the above medical necessity criteria are met AND there is documentation of beneficial response.

Authorization Duration

Initial approval duration: up to 12 months
Reauthorization approval duration: up to 12 months

Conditions Not Covered

Any other use is considered experimental, investigational or unproven, including the following (this list may not be all inclusive):

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

Background

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.

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.

Revision Details

Type of Revision	Summary of Changes	Date
Selected Revision	The prerequisite step through a standard of care option was removed from the Standard and Value formulary approaches.	4/1/2024

The policy effective date is in force until updated or retired.