



Drug Coverage Policy

Effective Date03/01/2025

Coverage Policy Number.....IP0074

Policy Title.....Qbrexza

Hyperhidrosis – 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 where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. 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 Healthcare Coverage Policy

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 using a single

cloth once every 24 hours to clean dry skin on both of 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% topical solution is the most commonly prescribed agent.

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POLICY STATEMENT

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

Qbrexza is considered medically necessary when the following criteria are met:

FDA-Approved Indication

- 1. Hyperhidrosis, Primary Axillary.** Approve for 1 year if the patient meets ALL of 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)** Preferred product criteria is met for the product(s) as listed in the below table(s)

Employer Plans:

Product	Criteria
Qbrexza (glycopyrronium cloth 2.4%)	<u>Performance/Advantage/Total Savings Drug List Plans:</u> Patient meets ONE of the following (1 <u>or</u> 2): <ol style="list-style-type: none">1. Patient has tried, for at least 4 weeks, and experienced inadequate efficacy with Drysol (aluminum chloride 20% topical solution)2. According to the prescriber, the patient has experienced significant intolerance with a prescription topical aluminum chloride product

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.

Qbrexza for any other use is considered not medically necessary, 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
2. **Concurrent Use with Sofdra (sofpironium 12.45% topical gel).** The safety and efficacy of concurrent use of Qbrexza and Sofdra have not been established.

References

1. Qbrexza™ cloth [prescribing information]. Scottsdale, AZ: Journey Medical; December 2023.
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 April 26, 2024.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	Hyperhidrosis, Primary Axillary: Updated "Documentation of failure, contraindication or intolerance to at least ONE prescription aluminum chloride-containing topical antiperspirant applied for at least 4 weeks." to now read, "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. Added "The prescriber has excluded secondary causes of hyperhidrosis."	7/1/2024
Selected Revision	Updated the title of the policy from ""Qbrexza" to "Hyperhidrosis – Qbrexza." Conditions Not Covered: Added concurrent use of Qbrexza with Sofdra (sofpironium 12.45% topical gel) to the Policy.	09/15/2024
Selected Revision	Removed the requirement for a patient to have tried, or experienced significant intolerance, to one prescription aluminum chloride-containing topical antiperspirant. Added a preferred product requirement, with a step through Drysol, for the Standard and Value Drug Plans.	10/15/2024
Selected Revision	Updated the formularies addressed in the Employer Plans preferred product requirement table.	03/01/2025

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

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