Clinical Policy: Aprocitentan (Tryvio)

Reference Number: LA.PHAR.676
Effective Date
Last Review Date: 05.24.24
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

****Please note: This policy is for medical benefit****

Description

Aprocitentan (Tryvio™) is an endothelin receptor antagonist.

FDA Approved Indication(s)

Tryvio is indicated for the treatment of hypertension in combination with other antihypertensive drugs, to lower blood pressure in adult patients who are not adequately controlled on other drugs. Lowering blood pressure reduces the risk of fatal and non-fatal cardiovascular events, primarily strokes and myocardial infarctions.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Louisiana Healthcare Connections that Tryvio is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Hypertension (must meet all)**:**

1. Diagnosis of hypertension;
2. Age ≥ 18 years;
3. Documentation of recent (within the last 30 days) blood pressure ≥ 140/90 mmHg, and both of the following (a and b):
   a. Tryvio is prescribed concurrently with an antihypertensive regimen containing THREE or more drug classes, unless clinically significant adverse effects are experienced or all are contraindicated (*see Appendix B*);
   b. Member has been adherent for at least the last 4 weeks at up to maximally tolerated doses of an antihypertensive drug regimen containing at least three different antihypertensive drug classes;
4. Tryvio is not prescribed concurrently with endothelin receptor antagonists (e.g., ambrisentan [Letairis®], bosentan [Tracleer®], Opsumit®, Filspari™);
5. Dose does not exceed 12.5 mg (1 tablet) per day.

Approval duration: 6 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53

II. Continued Therapy

A. Hypertension (must meet all)**:**

1. Currently receiving medication via Louisiana Healthcare Connections benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. Tryvio is not prescribed concurrently with endothelin receptor antagonists (e.g., ambrisentan [Letaris], bosentan [Tracleer], Opsumit, Filspari);
1. 4. If request is for a dose increase, new dose does not exceed 12.5 mg (1 tablet) per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to LA.PMN.255
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy LA.PMN.53

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – LA.PMN.53.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
REM: restricted distribution program

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Thiazide or thiazide-type diuretics (e.g., chlorthalidone, hydrochlorothiazide (HCTZ), metolazone)	Varies	Varies

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Angiotensin-converting enzyme (ACE) inhibitors (e.g., benazepril, captopril, enalapril, lisinopril, quinapril)	Varies	Varies
Angiotensin-receptor blockers (ARB) (e.g., candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan)	Varies	Varies
Calcium-channel blockers (e.g., amlodipine, nicardipine, diltiazem, verapamil)	Varies	Varies
Loop diuretics (e.g., bumetanide, furosemide, torsemide)	Varies	Varies
Potassium sparing diuretics (e.g., amiloride, triamterene)	Varies	Varies
Aldosterone antagonists (e.g., spironolactone, eplerenone)	Varies	Varies
Beta blockers (e.g., atenolol, bisoprolol, metoprolol, propranolol, carvedilol)	Varies	Varies
Direct renin inhibitor (e.g., aliskiren)	Varies	Varies
Alpha-1 blockers (e.g., doxazosin, prazosin, terazosin)	Varies	Varies
Centrally acting drugs (e.g., clonidine, methyldopa, guanfacine)	Varies	Varies
Direct vasodilators (e.g., hydralazine, minoxidil)	Varies	Varies

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): pregnancy; hypersensitivity
- Boxed warning(s): embryo-fetal toxicity; Tryvio is only available through a restricted distribution (REMS)

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Hypertension	12.5 mg PO QD	12.5 mg/day

VI. Product Availability

Tablet: 12.5 mg

VII. References

1. Tryvio Prescribing Information. Radnor, PA: Idorsia Pharmaceuticals US Inc. March 2024. Available at: https://www.tryvio.com. Accessed March 27, 2024.
2. Clinical Pharmacology [database online]. Tampa, FL: Elsevier; 2024. URL: www.clinicalkeys.com/pharmacology.

3. Danaietash P, Verweij P, Wang JG, et al; PRECISION investigators. Identifying and treating resistant hypertension in PRECISION: A randomized long-term clinical trial with aprocitentan. *J Clin Hypertens* (Greenwich). 2022 Jul;24(7):804-813. doi: 10.1111/jch.14517. Epub 2022 Jun 9.
4. Whelton PK, Carey RM, Aronow WS, et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the prevention, detection, evaluation, and management of high blood pressure in adults: A report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Hypertension*. 2018 Jun;71(6):1269-1324. doi: 10.1161/HYP.0000000000000066. Epub 2017 Nov 13. Erratum in: Hypertension. 2018 Jun;71(6):e136-e139. Erratum in: Hypertension. 2018 Sep;72(3):e33.
5. Carey RM, Calhoun DA, Bakris GL, et al; Resistant hypertension: Detection, evaluation, and management: A scientific statement from the American Heart Association. *Hypertension*. 2018 Nov;72(5):e53-e90. doi: 10.1161/HYP.0000000000000084.
6. Arguedas JA, Leiva V, Wright JM. Blood pressure targets in adults with hypertension. *Cochrane Database Syst Rev*. 2020 Dec 17;12(12):CD004349. doi: 10.1002/14651858.CD004349.pub3.

Reviews, Revisions, and Approvals	Date	LDH Approval Date
Converted to Local Policy	05.24.24	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the

requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

This clinical policy is the property of LHCC. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.