UnitedHealthcare Community Plan

Clinical Pharmacy Program Guidelines for Lovenox

Program	Prior Authorization
Medication	Enoxaparin (Lovenox)
Markets in Scope	California, Colorado, Hawaii, Maryland, Nevada, New Jersey, New York, New York EPP, Pennsylvania CHIP, Rhode Island, South Carolina
Issue Date	6/2009
Pharmacy and Therapeutics Approval Date	12/2020
Effective Date	3/2021

1. Background:

Indications:

Lovenox is indicated for:

- Prophylaxis of deep vein thrombosis (DVT) in abdominal surgery, hip replacement surgery, knee replacement surgery, or medical patients with severely restricted mobility during acute illness
- Inpatient treatment of acute DVT with or without pulmonary embolism (PE)
- Outpatient treatment of acute DVT without pulmonary embolism
- Prophylaxis of ischemic complications of unstable angina and non-Q-wave myocardial infarction, when concurrently administered with aspirin therapy.
- Treatment of acute ST-segment elevation myocardial infarction (STEMI) managed medically or with subsequent percutaneous coronary intervention

2. Coverage Criteria:

A. Continuation of Therapy Upon Hospital Discharge

1. Will be approved as continuation of therapy upon hospital discharge

Authorization will be issued for 35 days.

B. Prophylaxis of DVT - Orthopedic Surgery

1. For deep vein thrombosis (DVT) prophylaxis

-AND-

2. Patient is undergoing one of the following:

   a. Hip fracture surgery
   b. Hip replacement surgery

c. Knee replacement surgery

Authorization will be issued for 35 days.

C. Prophylaxis of DVT - Abdominal Surgery

1. For deep vein thrombosis (DVT) prophylaxis following abdominal surgery

-AND-

2. Patient is at risk for thromboembolic complications

Authorization will be issued for 2 weeks.

D. Prophylaxis of DVT - Restricted Mobility

1. For deep vein thrombosis (DVT) prophylaxis in patients at risk for thromboembolic complications due to severely restricted mobility during acute illness

Authorization will be issued for 2 weeks.

E. DVT Treatment

1. For the treatment of acute deep vein thrombosis (DVT)

Authorization will be issued for 2 weeks.

F. Prophylaxis of Ischemic Complications

1. For prophylaxis of ischemic complications in **one** of the following:

   a. Unstable angina
   b. Non-Q-Wave myocardial infarction

Authorization will be issued for 2 weeks.

G. Acute ST-segment elevation myocardial infarction

1. For treatment of acute ST-segment elevation myocardial infarction (STEMI)

-AND-

2. **ONE** of the following:
   a. managed medically

b. managed with subsequent percutaneous coronary intervention

Authorization will be issued for 2 weeks.

H. Off-Label Uses

1. The use of this drug is supported by information from the appropriate compendia of current literature.*

-AND-

2. The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program.

Authorization will be issued for the compendia recommended duration of therapy, not to exceed 12 months.

*****Compendia of current literature: • American Hospital Formulary Service Drug Information • National Comprehensive Cancer Network Drugs and Biologics Compendium • Thomson Micromedex DrugDex • Clinical Pharmacology • United States Pharmacopoeia-National Formulary (USP-NF)

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Lovenox [package insert]. Bridgewater, NJ: Sanofi-Aventis; May 2020.

Program	**Lovenox –Prior Authorization**
Change Control	
Date	**Change**
6/2009	Criteria taken from previously approved Unison policy, RX06 Low Molecular Weight Heparins. Policy was reformatted and renamed. Long term approval criteria clarified.

9/2009	Long term approval periods adjusted based upon CHEST guidelines.
12/2010	Annual Review
12/2011	Annual Review
12/2012	Annual Review
12/2014	Full review and clinical criteria updated to align across the UHC enterprise. Criteria sections changed to address each individual indication or off-label indication rather than sections based on length of therapy (acute, long term, or prevention).
4/2015	Added two additional requirement options in the section "Prophylaxis of VTE in patients withholding warfarin": • Atrial fibrillation with CHADs score of 5 or 6 • Atrial fibrillation with Rheumatic valvular heart disease
10/2016	No changes. Policy template updated but no changes made to policy content.
3/2017	Changed cancer and pregnancy authorization durations to 12 months. Updated policy template.
8/2018	Annual review. Minor updates to the background.
12/2019	Annual review. Updated background. Removed off-label criteria and added general off-label section. Updated references.
12/2020	Annual review. Added myocardial infarction criteria. Updated references.