# Clinical Policy: Celecoxib (Celebrex)

Reference Number: CP.PMN.122
Effective Date: 01.01.07
Last Review Date: 05.18
Line of Business: Commercial, HIM, Medicaid Revision Log

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

## Description

Celecoxib (Celebrex®) is a nonsteroidal anti-inflammatory drug (NSAID).

## FDA Approved Indication(s)

Celebrex is indicated for the treatment of:

- Osteoarthritis
- Rheumatoid arthritis
- Juvenile rheumatoid arthritis in patients 2 years and older
- Ankylosing spondylitis
- Acute pain
- Primary dysmenorrhea

## 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 health plans affiliated with Centene Corporation® that Celebrex is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. All Indications** (must meet all)**:**

1. Age ≥ 2 years;
2. Member meets one of the following (a, b, c, d, or e):
   a. Age > 65 years;
   b. Current use of corticosteroid;
   c. Current use of an anticoagulant (e.g., aspirin, warfarin, low molecular weight heparin, direct thrombin inhibitors, factor Xa inhibitors, clopidogrel);
   d. Prior gastrointestinal bleed or active peptic ulcer disease (not gastroesophageal reflux disease [GERD]);
   e. Both of the following (i and ii):
      i. Failure of a ≥ 4 week trial of meloxicam at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;
      ii. Failure of a ≥ 4 week trial of one additional generic NSAID at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;
3. Dose does not exceed 800 mg/day (2 capsules/day).

**Approval duration:**

**Medicaid/HIM -** 12 months
**Commercial -** Length of Benefit

**B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## II. Continued Therapy

**A. All Indications** (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 800 mg/day (2 capsules/day).
   **Approval duration:**
   **Medicaid/HIM -** 12 months
   **Commercial -** Length of Benefit

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   **Approval duration: Duration of request or months (whichever is less)**; or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## 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 – CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

## IV. Appendices/General Information

*Appendix A: Abbreviation/Acronym Key*
FDA: Food and Drug Administration
GERD: gastroesophageal reflux disease
NSAID: nonsteroidal anti-inflammatory drug

*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 for all relevant lines of business and may require prior authorization.*

| Drug Name | Dosing Regimen | Dose Limit/ Maximum Dose |
|---|---|---|
| Naproxen sodium (Anaprox®, Anaprox DS®) | 275 - 550 mg PO BID | 1650 mg/day |
| Sulindac (Clinoril®) | 150 mg - 200 mg PO BID | 400 mg/day |
| Salsalate (Disalcid®) | 500 - 750 mg PO TID, titrated up to 3000 mg/day | 3000 mg/day |
| Piroxicam (Feldene®) | 10 - 20 mg PO QD | 20 mg/day |
| Indomethacin (Indocin®) | 25 - 50 mg PO BID -TID | 200 mg/day |
| Indomethacin SR (Indocin® SR) | 75 mg PO QD - BID | 150 mg/day |
| Meclofenamate (Meclomen®) | 50 - 100 mg PO Q4-6hr | 400 mg/day |
| Meloxicam (Mobic®) | 7.5 – 15 mg PO QD | 15 mg/day |
| Ibuprofen (Motrin®) | 400 - 800 mg PO Q6-8hr | 3200 mg/day |
| Fenoprofen (Nalfon®) | 200 mg PO Q4-6hr | 3200 mg/day |
| Naproxen (Naprosyn®) | 250 – 500 mg PO BID | 1500 mg/day |
| Ketoprofen (Orudis®) | 25 - 75 mg PO Q6-8hr | 300 mg/day |
| Nabumetone (Relafen®) | 1000 mg PO QD or 500 mg PO BID | 2000 mg/day |
| Tolmetin (Tolmetin® DS) | 400 mg PO TID, titrated up to 1800 mg/day | 1800 mg/day |
| Diclofenac sodium (Voltaren®) | 50 mg PO TID | 150 mg/day |
| Oxaprozin (Daypro®) | 600 - 1200 mg PO BID | 1800 mg/day |
| Etodolac (Lodine®) | 400 - 500 mg PO BID | 1200 mg/day |

*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: General Information*

- The risk vs. benefit of COX-II therapy should be individualized based on patient's previous GI history, other co-morbid conditions (e.g., angina, ischemic heart disease, myocardial infarction (MI), coronary artery disease, stroke), age, concurrent medications (e.g., warfarin, oral corticosteroids), duration and dose.
- Celebrex has been associated with an increased risk of serious adverse cardiovascular (CV) events in a long-term placebo controlled trial. Based on the currently available data, FDA has concluded that an increased risk of serious adverse CV events appears to be a class effect of NSAIDs. FDA has requested that the package insert for all NSAIDs, including Celebrex, be revised to include a boxed warning to highlight the potential increased risk of CV events and the well described risk of serious, and potentially life-threatening, gastrointestinal bleeding.

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| Osteoarthritis | 200 mg once daily or 100 mg twice daily | 800 mg/day |
| Rheumatoid arthritis | 100 to 200 mg twice daily | 800 mg/day |

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| Juvenile rheumatoid arthritis | 50 mg twice daily in patients 10–25 kg<br>100 mg twice daily in patients more than 25 kg | 200 mg/day |
| Ankylosing spondylitis | 200 mg once daily single dose or 100 mg twice daily. If no effect is observed after 6 weeks, a trial of 400 mg (single or divided doses) may be of benefit | 800 mg/day |
| Acute pain | 400 mg initially, followed by 200 mg dose if needed on first day. On subsequent days, 200 mg twice daily as needed | 800 mg/day |
| Primary dysmenorrhea | 400 mg initially, followed by 200 mg dose if needed on first day. On subsequent days, 200 mg twice daily as needed | 800 mg/day |

## VI. Product Availability

Capsules: 50 mg, 100 mg, 200 mg, and 400 mg

## VII. References

1. Celecoxib Drug Monograph. Clinical Pharmacology. Accessed December 2017. http://www.clinicalpharmacology-ip.com.
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3. Lanza FL, Chan FK, Quigley EM et al. Guidelines for prevention of NSAID-related ulcer complications. Am J Gastroenterol. 2009 Mar;104(3):728-38. doi: 10.1038/ajg.2009.115. Epub 2009 Feb 24.
4. Hochberg MC, Altman RD, April KT et al. American College of Rheumatology 2012 recommendations for the use of nonpharmacologic and pharmacologic therapies in osteoarthritis of the hand, hip, and knee. Arthritis Care Res (Hoboken). 2012 Apr;64(4):465-74.
5. Ringold S, Weiss PF, Beukelman T et al. 2013 update of the 2011 American College of Rheumatology recommendations for the treatment of juvenile idiopathic arthritis: recommendations for the medical therapy of children with systemic juvenile idiopathic arthritis and tuberculosis screening among children receiving biologic medications. Arthritis Rheum. 2013 Oct;65(10):2499-512. doi: 10.1002/art.38092.
6. Ware MM, Deodhar A, Akl EA et al. American College of Rheumatology/Spondylitis Association of America/Spondyloarthritis Research and Treatment Network 2015 Recommendations for the Treatment of Ankylosing Spondylitis and Nonradiographic Axial Spondyloarthritis. Arthritis Rheumatol. 2016 Feb;68(2):282-98. doi: 10.1002/art.39298.
7. Yeomans ND. A comparison of omeprazole with ranitidine for ulcers associated with nonsteroidal anti-inflammatory drugs. N Engl J Med 1998;338:727-734.
8. Silverstein, et al. Gastrointestinal toxicity with celecoxib vs. nonsteroidal antiinflammatory drugs for osteoarthritis and rheumatoid arthritis (CLASS Study). JAMA 2000;284:1247-1255.
9. Mukherjee, et al. Risk of cardiovascular events associated with selective COX-2 inhibitors. JAMA 2001;286:954-959.

10. Juni, et al. Are selective COX 2 inhibitors superior to traditional non steroidal anti-inflammatory drugs. BMJ 2002;324:1287-1288.
11. Solomon DH, et al. Relationship between selective cyclooxygenase-2 inhibitors and acute myocardial infarction in older adults. Circulation 2004;109(17):2068-2073.

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| Updated reference section to reflect current literature search | 02.14 | 02.14 |
| Updated reference section to reflect current literature search. | 02.15 | 02.15 |
| Converted to new template<br>Removed criteria C: No reported allergy to sulfonamides, or ASA or other<br>NSAIDs (e.g., asthma, urticaria or other allergic reaction)<br>Removed Criteria D: Patient does not have severe renal insufficiency – an eGFR (estimated glomerular filtration rate) below 30 OR<br>severe hepatic impairment (Child-Pugh Class C) as safety criteria will be programmed as a safety edit<br>Initial approval time for all indications adjusted to 3 months for patients without risk for GI toxicity. | 08.15 | 08.15 |
| Updated references to reflect current literature search and updated formatting;<br>Removed requirement that request does not exceed 2 capsules/day and changed to a general statement to exceed FDA and plan limits. | 04.16 | 05.16 |
| Converted to new template; Added quantity and dosage limit;<br>Removed age criteria as age is not an absolute contraindication;<br>Updated references | 03.17 | 05.17 |
| 2Q 2018 annual review: polices combined for Medicaid, HIM, and commercial lines of business; reference number changed from PPA to PMN; Medicaid: Added age and max dose; increased approval duration from 3/12 to 12/12; HIM: removed specific diagnoses; added age; decreased trials from 3 (meloxicam & 2 NSAIDs) to 2 (meloxicam & 1 NSAID); added a path to approval for those with high risk for gastroduodenal damage (>65 years, current steroid or anticoagulant use, or prior bleed); Commercial: added age; changed trial of 2 NSAIDs to meloxicam and 1 NSAID; references reviewed and updated. | 2.20.18 | 05.18 |

**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. The Health Plan 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. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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 Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. 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. The Health Plan 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 the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. 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.

**Note:**
**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**For Health Insurance Marketplace members**, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.