

Clinical Policy: Dalteparin (Fragmin)

Reference Number: CP.PHAR.225

Effective Date: 05/16

Last Review Date: 05/17

[Coding Implications](#)
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See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The intent of the criteria is to ensure that patients follow selection elements established by Centene® clinical policy for dalteparin (Fragmin®).

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation® that dalteparin is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Venous Thrombosis (must meet all):

1. Request is for treatment in the outpatient setting;
2. Member has a contraindication to or has failed a trial of enoxaparin;
3. Any of the following indications:
 - a. Prevention/prophylaxis of venous thrombosis:
 - i. Surgery:
 - a) Total hip or knee replacement surgery;
 - b) Hip fracture surgery;
 - c) Other major orthopedic surgery including spinal surgery;
 - d) Major traumatic injury;
 - e) General and abdominal-pelvic;
 - f) Cardiac or thoracic surgery;
 - g) Craniotomy;
 - ii. Critical illness;
 - iii. Restricted mobility:
 - a) Severely restricted mobility during acute illness;
 - b) Impaired mobility in the presence of acute stroke or primary intracerebral hemorrhage;
 - iv. Cardiology:
 - a) Unstable angina and non-Q-wave myocardial infarction;
 - b) Atrial fibrillation when undergoing cardioversion;
 - c) Mechanical heart valve;
 - v. Cancer;
 - b. Treatment of venous thrombosis:
 - i. Deep vein thrombosis (DVT) or pulmonary embolism (PE);
 - ii. Superficial vein thrombus;
 - iii. Cerebral venous sinus thrombosis;
 - iv. Splanchnic (gastric, small/large intestine [mesentery venous thrombosis], pancreatic, hepatic [portal], splenic) vein thrombosis;
 - v. Nonbacterial thrombotic endocarditis.

Approval duration: 3 months

B. Anticoagulation in Pregnancy: Ante- and Postpartum (must meet all):

1. Request is for treatment in the outpatient setting;
2. Member has a contraindication to or has failed a trial of enoxaparin;
3. Member is pregnant or < 6 months postpartum;
4. Any of the following indications:
 - a. Acute venous thrombosis during current pregnancy;
 - b. Prior venous thrombosis;
 - c. Receiving long-term therapy with a vitamin K antagonist (e.g., warfarin);
 - d. Prosthetic heart valve;
 - e. Inherited thrombophilia ;
 - f. Antiphospholipid antibody syndrome;
 - g. Development of severe ovarian hyperstimulation syndrome post assisted reproduction;
 - h. Cesarean section - current pregnancy and request is for the postpartum period.

Approval duration:

Antepartum: to estimated delivery date (EDD)

Postpartum: to 6 months postpartum (3 month approvals)

C. Other diagnoses/indications: Refer to CP.PHAR.57 - Global Biopharm Policy.

II. Continued Approval

A. Venous Thrombosis (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria, and documentation supports positive response to therapy;
2. Continued use is limited to one of the following:
 - a. Venous thrombosis prophylaxis or treatment in the presence of cancer;
 - b. Recurrent venous thrombosis on a non-low molecular weight heparin (LMWH) anticoagulation therapy;
 - c. Any other indication in section I.A where bridging to warfarin is inappropriate or member has a contraindication to warfarin and extended (indefinite duration) anticoagulation therapy is required.

Approval duration: 6 months

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

1. Currently, receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

2. Refer to CP.PHAR.57 - Global Biopharm Policy.

Background*Description/Mechanism of Action:*

Fragmin Injection (dalteparin sodium injection) is a sterile, LMHW. It is available in single-dose, prefilled syringes preassembled with a needle guard device, and multiple-dose vials. Dalteparin is a LMHW with antithrombotic properties. It acts by enhancing the inhibition of Factor Xa and thrombin by antithrombin. In humans, dalteparin potentiates preferentially the inhibition of coagulation Factor Xa, while only slightly affecting the activated partial thromboplastin time.

Formulations:

Solution, Subcutaneous:

- Fragmin: 25,000 units/mL (95,000 units/3.8 mL (3.8 mL) [contains benzyl alcohol]

Solution, Subcutaneous [preservative free]:

- Fragmin: 10,000 units/mL (1 mL); 2500 units/0.2 mL (0.2 mL); 5000 units/0.2 mL (0.2 mL); 7500 units/0.3 mL (0.3 mL); 12,500 units/0.5 mL (0.5 mL); 15,000 units/0.6 mL (0.6 mL); 18,000 units/0.72 mL (0.72 mL)

FDA Approved Indications:

Fragmin is indicated for:

- Prophylaxis of ischemic complications in unstable angina and non-Q-wave myocardial infarction, when concurrently administered with aspirin therapy;
- Prophylaxis of DVT, which may lead to PE:
 - In patients undergoing hip replacement surgery;
 - In patients undergoing abdominal surgery who are at risk for thromboembolic complications;
 - In medical patients who are at risk for thromboembolic complications due to severely restricted mobility during acute illness;
- Extended treatment of symptomatic venous thromboembolism (VTE: proximal DVT and/or PE), to reduce the recurrence of VTE in patients with cancer. In these patients, the Fragmin therapy begins with the initial VTE treatment and continues for six months.

Limitations of use:

- Fragmin is not indicated for the acute treatment of VTE.

Appendices**Appendix A: Abbreviation Key**

DVT: deep vein thrombosis

LMWH: low molecular weight heparin

PE: pulmonary embolism

VTE: venous thromboembolism (typically refers to DVT or PE)

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J1645	Injection, dalteparin sodium, per 2500 IU

Reviews, Revisions, and Approvals	Date	Approval Date
Policy combines Fragmin information from the CP.PHAR.04.LMWH policy and the CP.PHAR.45 Anticoagulant Therapy Pregnancy policy. Added indication for “Thromboembolic complications due to acute thromboembolic stroke with impaired mobility.” Added bridge to or contraindication to warfarin for DVT without PE. Added requirement for additional VTE risk factor for Cesarean section indication, as well as bridge to warfarin if anticoagulation therapy is required > 6 weeks. Added an indication for receiving long-term therapy with a vitamin K antagonist per the Chest guidelines. Added continuation criteria for VTE in presence of cancer.	04/16	05/16
Section I.A. Criteria are edited to follow CHEST 2012 and 2016 guidelines in addition to labeled indications. Major additions include 1) prophylaxis: hip fracture/knee replacement, major orthopedic, general, cardiac, thoracic surgery, craniotomy; traumatic injury; critical illness; restricted mobility due to intracerebral hemorrhage; a-fib; prosthetic heart valve; 2) treatment: SVT; CVST; splanchnic thrombosis without cancer; nonbacterial thrombotic endocarditis. Warfarin bridging criteria are moved to renewal criteria. Safety information is removed. Removed section I.B. Required risk factors associated with Cesarean. Added preferencing for enoxaparin. Section II. Criteria are edited to follow CHEST 2016 guidelines. Major additions include 1) recurrent venous thrombosis on a non-low molecular weight heparin, 2) any other indication in section I.A., where bridging to warfarin is inappropriate or member has a contraindication to warfarin and extended (indefinite) anticoagulation therapy is required.	04/17	05/17

References

1. Fragmin Prescribing Information. New York, NY: Pfizer, Inc.; August 2016. Available at <http://labeling.pfizer.com/ShowLabeling.aspx?id=2293>. Accessed April 17, 2017.
2. Dalteparin. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed April 17, 2017.
3. Dalteparin: Drug information. In: UpToDate (Lexicomp), Waltham, MA: Walters Kluwer Health; 2017. Available at uptodate.com. Accessed April 17, 2017.
4. Kearon C, Akl EA, Ornelas J, et al. Antithrombotic therapy for VTE disease: CHEST guideline and expert panel report. *Chest*. 2016; 149(2): 315-352.
5. Bates SM, Greer IA, Middeldorp S, et al. VTE, thrombophilia, antithrombotic therapy, and pregnancy: Antithrombotic therapy and prevention of thrombosis, 9th ed: American College of Chest Physicians evidence-based clinical practice guidelines. *Chest*. 2012; 141(2 Suppl): e691S-736S.

6. Beauer KA, Lip GYH. Overview of the causes of venous thrombosis. In: UpToDate, Waltham, MA: Walters Kluwer Health; 2017. Available at uptodate.com. Accessed April 24, 2017.
7. Thromboembolism in pregnancy. Practice Bulletin No. 123. American College of Obstetrics and Gynecologists. *Obstet Gynecol.* 2011; 118: 718-729.
8. Cancer-associated venous thromboembolic disease. In: National Comprehensive Cancer Network Drugs and Biologics Compendium. Available at nccn.org. Accessed April 18, 2017.

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.

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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.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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