

Clinical Policy: Roflumilast (Daliresp, Zoryve)

Reference Number: CP.PMN.46

Effective Date: 11.01.11

Last Review Date: 11.22

Line of Business: Commercial, Medicaid

[Revision Log](#)

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

Description

Roflumilast (Daliresp[®], Zoryve[™]) is a selective phosphodiesterase 4 inhibitor.

FDA Approved Indication(s)

Daliresp is indicated as a treatment to reduce the risk of chronic obstructive pulmonary disease (COPD) exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations.

Zoryve is indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 12 years of age and older.

Limitation(s) of use:

- Daliresp is not a bronchodilator and is not indicated for the relief of acute bronchospasm.
- Daliresp 250 mcg is a starting dose for the first 4 weeks of treatment only and is not the effective (therapeutic) dose.

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 Daliresp and Zoryve are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria**A. Chronic Obstructive Pulmonary Disease (must meet all):**

1. Request is for roflumilast tablet (Daliresp);
2. Diagnosis of COPD;
3. Age \geq 18 years;
4. Current (within the past 30 days) forced expiratory volume in one second (FEV₁) $<$ 50% predicted;
5. Member meets one of the following (a or b):
 - a. Failure of triple inhaled therapy consisting of a combination of a long-acting beta₂-agonist (LABA), long-acting antimuscarinic antagonist (LAMA), and inhaled corticosteroid (ICS) at up to maximally indicated doses;
 - b. Both i and ii:
 - i. Failure of dual inhaled therapy consisting of a combination of a LABA and LAMA at up to maximally indicated doses;

- ii. Current (within the past 30 days) blood eosinophil count < 100 cells/uL;
- 6. Daliresp is prescribed concurrently with a long-acting bronchodilator (i.e., LABA or LAMA);
- 7. Dose does not exceed both of the following (a and b):
 - a. 500 mcg per day;
 - b. 1 tablet per day.

Approval duration: 12 months

B. Plaque Psoriasis (must meet all):

- 1. Request is for roflumilast cream (Zoryve);
- 2. Diagnosis of plaque psoriasis with body surface area involvement $\leq 20\%$;
- 3. Prescribed by or in consultation with a dermatologist or rheumatologist;
- 4. Age ≥ 12 years;
- 5. Member meets one of the following (a or b):
 - a. Failure of both (i and ii) used concurrently, unless clinically significant adverse effects are experienced or all are contraindicated:
 - i. Medium to ultra-high potency topical corticosteroid (*see Appendix B*);
 - ii. Calcipotriene, calcitriol, or tazarotene;
 - b. For face or intertriginous areas (e.g., genitals, armpits, forearms, and groin): Failure of a topical calcineurin inhibitor* (*see Appendix B*), unless contraindicated or clinically adverse effects are experienced;
- 6. Request does not exceed 1 tube per month.

**Prior authorization may be required for topical calcineurin inhibitors*

Approval duration: 12 months

C. 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 one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial and CP.PMN.16 for Medicaid; or
- 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 for the relevant line of business: CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Chronic Obstructive Pulmonary Disease (must meet all):

- 1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;

- b. Member is receiving benefit from the referenced states for the applicable product and regulation (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
- 2. Request is for roflumilast tablet (Daliresp);
- 3. Member is responding positively to therapy;
- 4. If request is for a dose increase, new dose does not exceed both of the following (a and b):
 - a. 500 mcg per day;
 - b. 1 tablet per day.

Approval duration: 12 months

B. Plaque Psoriasis (must meet all):

- 1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is receiving benefit from the referenced states for the applicable product and regulation (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
- 2. Request is for roflumilast cream (Zoryve);
- 3. Member is responding positively to therapy;
- 4. If request is for a dose increase, new dose does not exceed 1 tube per month.

Approval duration: 12 months

C. 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 one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial and CP.PMN.16 for Medicaid; or
- 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 for the relevant line of business: CP.CPA.09 for commercial 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 and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

COPD: chronic obstructive pulmonary disease

FDA: Food and Drug Administration

FEV₁: forced expiratory volume in one second

ICS: inhaled corticosteroid

LABA: long-acting beta₂-agonist

LAMA: long-acting antimuscarinic antagonist

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.

COPD		
Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
ICS/LABA Combinations		
fluticasone/salmeterol (Advair Diskus®)	Refer to prescribing information	Refer to prescribing information
Breo Ellipta® (fluticasone/vilanterol)		
budesonide/formoterol (Symbicort®)		
Dulera®* (mometasone/formoterol)	Doses of 10 mcg formoterol/400 mcg mometasone and 10 mcg formoterol/200 mcg mometasone, each inhaled BID, have been studied	The optimal dose has not been established
LABA/LAMA Combinations		
Bevespi Aerosphere® (formoterol/glycopyrrolate)	Refer to prescribing information	Refer to prescribing information
Utibron Neohaler® (indacaterol/glycopyrrolate)		
Anoro Ellipta® (vilanterol/umeclidinium)		
Stiolto Respimat® (olodaterol/tiotropium)		
LAMAs		
Tudorza Pressair® (aclidinium bromide)	Refer to prescribing information	Refer to prescribing information
Seebri Neohaler® (glycopyrrolate)		
Spiriva Respimat®/HandiHaler® (tiotropium)		
Incruse Ellipta (umeclidinium)		
LABAs		
Brovana® (arformoterol)	Refer to prescribing information	

COPD		
Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Arcapta Neohaler [®] (indacaterol)		Refer to prescribing information
Striverdi Respimat [®] (olodaterol)		
Serevent Diskus [®] (salmeterol)		
ICS/LABA/LAMA Combinations		
Trelegy [™] Ellipta [®] (fluticasone/umeclidinium/ vilanterol)	1 inhalation by mouth QD	1 inhalation/day
Plaque Psoriasis		
Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
calcipotriene (Dovonex [®]) cream, ointment, solution	Apply topically to the affected area(s) BID	100 g/week
calcitriol (Vectical [™]) ointment	Apply topically to the affected area(s) BID	200 g/week
tazarotene (Tazorac [®]) gel, cream	Apply topically to the affected area(s) QHS	Once daily application
Ultra-High Potency Topical Corticosteroids		
augmented betamethasone dipropionate 0.05% (Diprolene [®] , Alphatrex [®]) ointment, gel	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
clobetasol propionate 0.05% (Temovate [®] , Temovate E [®]) cream, ointment, gel, solution		
diflorasone diacetate 0.05% (Apexicon [®]) ointment		
halobetasol propionate 0.05% (Ultravate [®]) cream, ointment		
High Potency Topical Corticosteroids		
augmented betamethasone dipropionate 0.05% (Diprolone [®] , Diprolene [®] AF) cream, lotion	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
betamethasone dipropionate 0.05% ointment		

Plaque Psoriasis		
Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
desoximetasone (Topicort®) 0.25%, 0.05% cream, ointment, gel		
diflorasone 0.05% (Apexicon E®) cream		
fluocinonide acetonide 0.05% cream, ointment, gel, solution		
triamcinolone acetonide 0.5% (Aristocort®, Kenalog®) cream, ointment		
Medium/Medium to High Potency Topical Corticosteroids		
betamethasone dipropionate 0.05% cream	Apply topically to the affected area(s) BID	Should not be used for longer than 2 consecutive weeks
desoximetasone 0.05% (Topicort®) cream, ointment, gel		
fluocinolone acetonide 0.025% (Synalar®) cream, ointment		
fluticasone propionate 0.05% (Cutivate®) cream		
mometasone furoate 0.1% (Elocon®) cream, lotion, ointment		
triamcinolone acetonide 0.1%, 0.25%,0.5% (Aristocort®, Kenalog®) cream, ointment		
Combination Corticosteroid + (Vitamin D Analog or Retinoid)		
Enstilar® (calcipotriene 0.005% and betamethasone dipropionate 0.064%) foam	Apply topically to affected areas QD for up to 4 weeks. Avoid use on face, groin, axillae, skin treatment site with atrophy present, or with occlusive dressing unless directed by a healthcare provider	60 g/4 days
Duobrii® (halobetasol propionate 0.01% and tazarotene 0.045%) lotion	Apply a thin layer of lotion once daily to affected areas until control is achieved	50 g/week
Topical Calcineurin Inhibitors		
tacrolimus (Protopic®) (off-label)	Apply twice daily to psoriatic lesions of the face and intertriginous areas	2 applications/day

Plaque Psoriasis		
Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
pimecrolimus (Elidel [®]) (off-label)	Apply twice daily to affected intertriginous areas	2 applications/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.

*Off-label

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): moderate to severe liver impairment (Child-Pugh B or C)
- Boxed warning(s): none reported

V. Dosage and Administration

Drug Name	Indication	Dosing Regimen	Maximum Dose
Daliresp	COPD	500 mcg PO QD (starting treatment with 250 mcg QD for 4 weeks and increasing to 500 mcg QD thereafter may reduce the rate of discontinuation in some patients)	500 mcg/day
Zoryve	Plaque psoriasis	Apply cream to affected areas once daily	Once daily application

VI. Product Availability

Drug Name	Availability
Daliresp	Tablets: 250 mcg, 500 mcg
Zoryve	Cream (0.3%): 60 g tube

VII. References

1. Daliresp Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals; March 2020. Available at: <https://www.daliresp.com/>. Accessed March 30, 2022.
2. Zoryve Prescribing Information. Westlake Village, CA: Arcutis Biotherapeutics, Inc; July 2022. Available at <https://www.zoryvehcp.com/>. Accessed August 5, 2022.
3. Global Initiative for Chronic Obstructive Lung Disease (GOLD): Global strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease (2022 report). Available from: <http://www.goldcopd.org/>. Accessed March 30, 2022.
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2022. Available at: <http://www.clinicalpharmacology-ip.com/>. Accessed March 30, 2022.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2018 annual review: no significant changes; age restriction added, smoking cessation requirements removed as this cannot be enforced; initial approval duration increased from 6 to 12 months; references reviewed and updated.	04.09.18	08.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2019 annual review: added an additional pathway to approval for members failing LABA/LAMA with blood eosinophil count < 100 cells/uL per GOLD 2019 guideline; removed trial duration and instead required that preferred drugs be tried at up to maximally indicated doses to align with approach for other COPD agents; references reviewed and updated.	05.07.19	08.19
3Q 2020 annual review: no significant changes; references reviewed and updated.	04.15.20	08.20
3Q 2021 annual review: no significant changes; added Commercial line of business; references reviewed and updated.	03.17.21	08.21
3Q 2022 annual review: no significant changes; references reviewed and updated.	03.30.22	08.22
RT4: added criteria for newly FDA-approved dosage form (Zoryve cream) and indication of plaque psoriasis.	08.08.22	11.22
Template changes applied to other diagnoses/indications and continued therapy section.	11.07.22	

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.

©2011 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene[®] and Centene Corporation[®] are registered trademarks exclusively owned by Centene Corporation.