# Clinical Policy: Indomethacin (Tivorbex)

Reference Number: CP.CPA.292
Effective Date: 11.16.16
Last Review Date: 11.23
Line of Business: Commercial

Revision Log

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

## Description

Indomethacin (Tivorbex®) is a non-steroidal anti-inflammatory drug (NSAID).

## FDA Approved Indication(s)

Tivorbex is indicated for treatment of mild to moderate acute pain in adults.

## 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 Tivorbex is **medically necessary** when the following criteria are met:

**I. Initial Approval Criteria**

**A. Acute Pain** (must meet all)**:**

1. Diagnosis of acute pain;
2. Age ≥ 18 years;
3. Failure of one other preferred NSAID (*See Appendix B)* at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for brand Tivorbex, member must use generic indomethacin, unless contraindicated or clinically adverse effects are experienced;
5. Dose does not exceed 120 mg per day.

**Approval duration: 12 months or duration of request, whichever is less**

**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 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; 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; 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.

**II. Continued Therapy**

**A. Acute Pain** (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 currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 120 mg per day.

**Approval duration: 12 months or duration of request, whichever is less**

**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 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; 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; 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.

**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 policy – CP.CPA.09 or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key:*
CABG: coronary artery bypass graft
FDA: Food and Drug Administration
NSAID: non-steroidal 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 |
|---|---|---|
| indomethacin (Indocin®) | 25 - 50 mg PO BID-TID | 200 mg/day |
| indomethacin SR (Indocin® SR) | 75 mg PO QD - BID | 150 mg/day |
| diclofenac sodium (Voltaren®) | 50 mg PO TID | 200 mg/day |
| etodolac (Lodine®) | 400 - 500 mg PO BID | 1,200 mg/day |
| fenoprofen (Nalfon®) | 200 mg PO Q4-6hr | 3,200 mg/day |
| flurbiprofen (Ansaid®) | 100 mg PO BID-TID | 300 mg/day |
| ibuprofen (Motrin®) | 400 - 800 mg PO Q6-8hr | 3,200 mg/day |
| ketoprofen (Orudis®, Oruvail®) | 25-50 mg PO Q6-8hr | 300 mg/day |
| ketorolac tromethamine | 10 mg PO q4-6hr | 40 mg/day |
| meclofenamate (Meclomen®) | 50 - 100 mg PO Q4-6hr | 400 mg/day |
| meloxicam (Mobic®) | 7.5 mg -15 mg PO QD | 15 mg/day |
| nabumetone (Relafen®) | 1,000 mg PO QD | 2,000 mg/day |
| naproxen(Naprosyn®) | 250 - 500 mg PO BID | 1,500 mg/day |
| naproxen ER (Naprelan®) | 750 – 1,000 mg PO QD | 1,500 mg/day |
| naproxen sodium (Anaprox®, Anaprox DS®) | 275 - 550 mg PO BID | 1,650 mg/day |
| oxaprozin (Daypro™) | 600 - 1,200 mg PO QD | 1,800 mg/day |
| piroxicam (Feldene®) | 10 - 20 mg PO QD | 20 mg/day |
| salsalate(Disalcid®) | 500 - 750 mg PO BID-TID | 3,000 mg/day |
| sulindac (Clinoril®) | 150 mg - 200 mg PO BID | 400 mg/day |
| tolmetin (Tolectin®) | 200-600 mg PO TID | 1,800 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: Contraindications/Boxed Warnings*

- Contraindication(s): hypersensitivity to indomethacin or any components of the drug product; history of asthma, urticarial, or other allergic-type reactions after taking aspirin or other NSAIDs; in the setting of coronary artery bypass graft (CABG) surgery
- Boxed warning(s): cardiovascular thrombotic events; gastrointestinal bleeding, ulceration, and perforation

## V. Dosage and Administration

| Indication | Dosing Regimen | Maximum Dose |
|---|---|---|
| Acute pain | 20 mg PO TID or 40 mg PO BID - TID | 120 mg/day |

## VI. Product Availability

Capsules: 20 mg, 40 mg

## VII. References

1. Tivorbex Prescribing Information. Philadelphia, PA: Iroko Pharmaceuticals; February 2014. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/204768s000lbl.pdf. Accessed June 30, 2023.

2. Micromedex® Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed July 10, 2023.

| Reviews, Revisions, and Approvals | Date | P&T Approval Date |
|---|---|---|
| 4Q 2019 annual review: no significant changes; references reviewed and updated. | 08.25.19 | 11.19 |
| 4Q 2020 annual review: no significant changes; references reviewed and updated. | 08.21.20 | 11.20 |
| 4Q 2021 annual review: no significant changes; references reviewed and updated. | 06.25.21 | 11.21 |
| Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less | 09.27.21 | 02.22 |
| Q4 2022 annual review: changed to member must use language for generic indomethacin; no significant changes; references reviewed and updated. Template changes applied to other diagnoses/indications and continued therapy section. | 07.28.22 | 11.22 |
| 4Q 2023 annual review: no significant changes; references reviewed and updated. | 06.30.23 | 11.23 |

**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.

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