Clinical Policy: House Dust Mite Allergen Extract (Odactra)

Reference Number: PA.CP.PMN.111
Effective Date: 08/2022
Last Review Date: 07/2024

Description
House dust mite (*Dermatophagoides farinae* and *Dermatophagoides pteronyssinus*) allergen extract (Odactra™) is an allergen extract.

FDA Approved Indication(s)
Odactra is indicated as immunotherapy for the treatment of house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis, confirmed by *in vitro* testing for IgE antibodies to *Dermatophagoides farinae* or *Dermatophagoides pteronyssinus* house dust mites, or by positive skin testing to licensed house dust mite allergen extracts. Odactra is approved for use in persons 5 through 65 years of age.

Odactra is not indicated for the immediate relief of allergy symptoms.

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 PA Health & Wellness® that Odactra is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Allergic Rhinitis (must meet all)**:**

1. Diagnosis of HDM-induced allergic rhinitis;
2. Prescribed by or in consultation with an allergist or immunologist;
3. Age ≥ 5 years and ≤ 65 years;
4. Member meets one of the following (a or b):
   a. Confirmation of the presence of IgE antibodies to *Dermatophagoides farinae* or *Dermatophagoides pteronyssinus* HDM;
   b. Positive skin testing to licensed HDM allergen extracts;
5. Failure of one intranasal corticosteroid, unless clinically significant adverse effects are experienced or all are contraindicated;
6. Failure of one oral antihistamine at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated;
7. Dose does not exceed one tablet per day.

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

II. Continued Therapy

A. Allergic Rhinitis (must meet all)**:**

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.PHARM.01) applies;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed one tablet per day.

Approval duration: 12 months

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

1. Currently receiving medication via PA Health & Wellness benefit and documentation supports positive response to therapy or the Continuity of Care policy (PA.PHARM.01) applies;
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): PA.CP.PMN.53

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 – PA.CP.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
HDM: house dust mite

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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
OTC loratadine (Claritin®)	2 to 5 years: 5 mg PO QD ≥ 6 years: 10 mg PO QD	10 mg/day
OTC loratadine-D (Claritin-D® 12 and 24 hour)	≥ 12 years: 1 tablet PO BID (12 hr) QD (24 hr)	10 mg/day
OTC cetirizine (Zyrtec®)	6 months to < 1 year: 2.5 mg PO QD 1 to 5 years: 2.5-5 mg PO QD ≥ 6 years: 10 mg PO QD	10 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
OTC fexofenadine (Allegra Allergy®)	6-months to 2 years: 15 mg PO BID 2 to 11 years: 30 mg PO BID ≥ 12 years: 60 mg PO BID or 180 mg PO QD	180 mg/day
fluticasone propionate (Flonase®)	≥ 4 years: 1-2 sprays each nostril QD ≥ 12 years: 1-2 sprays each nostril QD	2 sprays each nostril/day
triamcinolone acetonide (Nasacort AQ®)	2-11 years: 1 spray each nostril QD ≥ 12 years: 1-2 sprays each nostril QD	2-11 years: 1 spray each nostril/day > 12 years: 2 sprays each nostril/day
mometasone furoate monohydrate (Nasonex®)	2-11 years: 1 spray each nostril QD ≥ 12 years: 2 sprays each nostril QD	2-11 years: 1 spray each nostril/day > 12 years: 2 sprays each nostril/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): severe, unstable or uncontrolled asthma; history of eosinophilic esophagitis; history of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy; hypersensitivity to any of the inactive ingredients contained in this product
- Boxed warning(s): severe allergic reactions

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
HDM-induced allergic rhinitis	One tablet SL QD	1 tablet/day

VI. Product Availability

Tablet: 12 SQ-HDM

VII. References

1. Odactra Prescribing Information. Round Rock, TX: Alk, Inc.; February 2025. Available at: https://www.odactra.com/assets/pdf/odactra-full-pi.pdf. Accessed March 18, 2025.
2. Nolte H, Bernstein DI, Nelson HS, et al. Efficacy of house dust mite sublingual immunotherapy tablet in North American adolescents and adults in a randomized, placebo-controlled trial. The Journal of Allergy and Clinical Immunology 2016; 138(6):1631-1638.
3. Demoly P, Emminger W, Rehm D, et al. Effective treatment of house dust mite-induced allergic rhinitis with 2 doses of the SQ HDM SLIT-tablet: Results from a randomized, double-blind, placebo-controlled phase III trial. The Journal of Allergy and Clinical Immunology 2016; 137(2) 444-451.

4. Nolte H, Maloney J, Nelson HS, et al. Onset and dose-related efficacy of house dust mite sublingual immunotherapy tablets in an environmental exposure chamber. The Journal of Allergy and Clinical Immunology 2015; 135(6):1494-1501.
5. Seidman MD, Gurgel RK, Lin SY, et al. Clinical practice guideline: allergic rhinitis. Otolaryngology – Head and Neck Surgery 2015; 152(1S):S1-S43.
6. Wallace DV, Dykewicz MS, Oppenheimer J et al. Pharmacologic treatment of seasonal allergic rhinitis: synopsis of guidance from the 2017 Joint Task Force on Practice Parameters. Ann Intern Med. 2017 Dec 19;167(12):876-881. doi: 10.7326/M17-2203.
7. Brozek, JL, Bousquet J, Agache I et al. Allergic rhinitis and its impact on asthma (ARIA) guidelines-2016 revision. J Allergy Clin Immunol. 2017 Oct;140(4):950-958. doi: 10.1016/j.jaci.2017.03.050.
8. Greenhawt M, Oppenheimer J, Nelson M, et al. Sublingual immunotherapy: A focused allergen immunotherapy practice parameter update. Ann Allergy Asthma Immunol. 2017; 118: 276-282.
9. Dykewicz MS, Wallace DV, Amrol DJ, et al. Rhinitis 2020: A practice parameter update. J Allergy Clin Immunol. 2020; 136(4): 721-767.

Reviews, Revisions, and Approvals	Date
Policy created	07/2022
RT4: updated criteria per FDA approved pediatric extension; updated Allegra dosing in Appendix B.	04/2023
3Q 2023 annual review: no significant changes; references reviewed and updated.	07/2023
3Q 2024 annual review: no significant changes; references reviewed and updated.	07/2024
RT4: updated indication and criteria with pediatric expansion to age 5 years.	04/2025