Clinical Policy: Short Ragweed Pollen Allergen Extract (Ragwitek)

Reference Number: PA.CP.PMN.83
Effective Date: 08/2022
Last Review Date: 07/2023

Revision Log

Description
Short ragweed pollen allergen extract (Ragwitek®) is an allergen extract.

FDA Approved Indication(s)
Ragwitek is indicated as immunotherapy for the treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen. Ragwitek is approved for use in persons 5 through 65 years of age.

Ragwitek is not indicated for the immediate relief of allergic 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 Ragwitek is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of short ragweed pollen-induced allergic rhinitis;
2. Prescribed by or in consultation with an allergist or immunologist;
3. Age ≥ 5 years and ≤ 65 years;
4. Confirmation of a positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen;
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 1 tablet per day.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

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.LTSS.PHAR.01) applies;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 1 tablet per day.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

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.LTSS.PHAR.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 policies – PA.CP.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

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
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: 5-10 mg PO QD	10 mg/day
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

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
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
Short ragweed pollen-induced allergic rhinitis	One tablet SL QD Treatment should be initiated at least 12 weeks before the expected onset of ragweed pollen season and continue treatment throughout the season.	1 tablet/day

VI. Product Availability

Tablet: 12 Amb a 1-Unit (Amb a 1-U)

VII. References

1. Ragwitek Prescribing Information. Whitehouse Station, NJ: Merck Sharp & Dohme Corp.; April 2021. Available at: https://www.ragwitek.com. Accessed April 14, 2023.
2. 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.
3. Seidman MD, Gurgel RK, Lin SY, et al. Clinical practice guideline: Allergic rhinitis. Otolaryngol Head Neck Surg. 2015 Feb;152(1 Suppl):S1-43. doi: 10.1177/0194599814561600.
4. Wallace DV, Dykewicz MS, Bernstein DI, Blessing-Moore J, Cox L, Khan DA, Lang DM, Nicklas RA, Oppenheimer J, Portnoy JM, Randolph CC, Schuller D, Spector SL, Tilles SA, Joint Task Force on Practice, American Academy of Allergy, Asthma & Immunology,

American College of Allergy, Asthma and Immunology, Joint Council of Allergy, Asthma and Immunology. The diagnosis and management of rhinitis: an updated practice parameter. J Allergy Clin Immunol. 2008;122(2 Suppl):S1-84.
5. Cox L, Nelson H, Lockey R, et al. Allergen immunotherapy: a practice parameter third update. J Allergy Clin Immunol. 2011 Jan;127(1 Suppl):S1-55.
6. 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.
7. 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.
8. 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	P&T Approval Date
Policy created	07/2022	
3Q 2023 annual review: no significant changes; updated Allegra dosing in Appendix B; references reviewed and updated.	07/2023	