SPECIALTY GUIDELINE MANAGEMENT

TIKOSYN (dofetilide)

POLICY

I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications
   - **A.** Maintenance of normal sinus rhythm (delay in time to recurrence of atrial flutter/atrial fibrillation [AF/AFI]) in patients with AF/AFl of greater than one week duration who have been converted to normal sinus rhythm
   - B. Conversion of AF/AFI to normal sinus rhythm

B. Compendial Uses
   1. Paroxysmal supraventricular tachycardia
   2. Ventricular tachyarrhythmias

All other indications are considered experimental/investigational and are not a covered benefit.

II. CRITERIA FOR APPROVAL

A. Atrial Flutter/Atrial Fibrillation
Authorization of 12 months may be granted for members prescribed Tikosyn for the maintenance of, or conversion to, normal sinus rhythm after atrial flutter or atrial fibrillation

B. Paroxysmal Supraventricular Tachycardia
Authorization of 12 months may be granted for members prescribe Tikosyn for the treatment and prophylaxis of paroxysmal supraventricular tachycardia

C. Ventricular Tachyarrhythmias
Authorization of 12 months may be granted for members prescribed Tikosyn for the treatment and prevention of ventricular tachyarrhythmias

III. CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet ALL initial authorization criteria.

IV. REFERENCES

1. Tikosyn [package insert]. New York, NY: Pfizer Inc.; July 2016.
2. Micromedex Solutions [database online]. Ann Arbor, MI: Truven Health Analytics Inc. Updated periodically. www.micromedexsolutions.com [available with subscription]. Accessed April 19, 2016.