Clinical Policy: Propranolol HCl Oral Solution (Hemangeol)

Reference Number: CP.PMN.58
Effective Date: 05.01.14
Last Review Date: 05.26
Line of Business: Medicaid

Revision Log

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

Description

Propranolol HCl oral solution (Hemangeol®) is a beta-adrenergic blocker.

FDA Approved Indication(s)

Hemangeol oral solution is indicated for the treatment of proliferating infantile hemangioma (IH) requiring systemic therapy.

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 Hemangeol is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Proliferating Infantile Hemangioma (must meet all)**:**

1. Diagnosis of proliferating IH;
2. Age ≥ 5 weeks;
3. Weight ≥ 2 kg;
4. Member must use generic propranolol HCl oral solution, unless contraindicated or clinically significant adverse effects are experienced.

Approval duration: 6 months

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.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.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, HIM.PA.154 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Proliferating Infantile Hemangioma (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. Member meets one of the following (a or b):
   a. Member has not received ≥ 12 months of consecutive therapy;
   b. Documentation supports recurrence of hemangioma.

Approval duration: 6 months

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.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.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.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.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
HCl: hydrochloride
IH: infantile hemangioma

Appendix B: Therapeutic Alternatives

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Propranolol HCl oral solution*	1 mg/kg/day PO initially in 2 to 3 divided doses, titrated to a target dose of 2 to 3 mg/kg/day initially in 2 to 3 divided doses, unless there are comorbidities (e.g., PHACE syndrome, progressive ulceration) or adverse reactions that require a lower dose	See regimen

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): premature infants with corrected age of less than 5 weeks, infants weighing less than 2 kg, asthma or history of bronchospasm, heart rate less than 80 beats/min, greater than first degree heart block, decompensated heart failure, blood pressure less than 50/30 mmHg, pheochromocytoma, hypersensitivity to propranolol or its excipients
- Boxed warning(s): none reported

Appendix D: Management of IH

- IHs are the most common benign tumors of infancy. While they often involute after proliferation, there are some that rapidly develop life-threatening complications, resulting ulceration, functional impairment, underlying abnormalities, or permanent disfiguration. Oral propranolol is the treatment of choice for problematic IHs that require systemic therapy.
- Although the most dramatic improvement using propranolol for IH occurs within 3 to 4 months of initiation of therapy, the optimal treatment duration has not been established:
  - The FDA recommends the maintenance dose be maintained for 6 months. This is likely based on the clinical trial for approval which evaluated patients after 6 months of treatment.
  - The American Academy of Pediatrics indicates that many continue therapy until patients reach an age when IH would normally begin to regress without treatment-often until at least 8 to 12 months of age, which, in most studies, equated to 3 to 12 months of therapy.
- While Hemangeol is effective, rebound growth has been observed in 10% to 25% of children. In the Hemangeol clinical trial, 10% of patients deemed successes after 6-months of therapy later required re-treatment for recurrence.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Proliferating IH	0.15 mL/kg (0.6 mg/kg) PO twice daily, increase to 0.3 mL/kg (1.1 mg/kg) twice daily after 1 week,	See regimen

Indication	Dosing Regimen	Maximum Dose
	then to a maintenance dose of 0.4 mL/kg (1.7 mg/kg) twice daily after 2 weeks	

VI. Product Availability

Oral solution: 4.28 mg/mL

VII. References

1. Hemangeol Prescribing Information. Parsippany, NJ: Pierre Fabre Pharmaceuticals, Inc; June 2021. Available at: https://hemangeol.com. Accessed January 23, 2026.
2. Darrow DH, Greene AK, Mancini AJ, et al. American Academy of Pediatrics clinical report (guidance for the clinician in rendering pediatric care): diagnosis and management of infantile hemangioma. Pediatrics. 2015; 136(4): e1060-e1104.
3. Krowchuk DP, Frieden IJ, Mancini AJ, et al: Clinical practice guideline for the management of infantile hemangiomas. Pediatrics 2019; 143(1):e20183475.
4. Sebaratnam DF, Rodriquez Bandera AI, Wong LF, Wargon O. Infantile hemangioma. Part 2: management. J Am Acad Dermatol. 2021;85(6):1395-1404.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2022 annual review: no significant changes; references reviewed and updated.	01.31.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.07.22	
2Q 2023 annual review: no significant changes; contraindications updated per PI; references reviewed and updated.	01.23.23	05.23
Per September SDC, added Commercial line of business.	09.21.23	12.23
Per December SDC, removed Commercial and HIM lines of business (separate policy created); added redirection to generic propranolol oral solution; references reviewed and updated.	12.06.23	02.24
2Q 2024 annual review: no significant changes; references reviewed and updated.	01.18.24	05.24
2Q 2025 annual review: no significant changes; references reviewed and updated.	01.13.25	05.25
2Q 2026 annual review: no significant changes; references reviewed and updated.	01.23.26	05.26

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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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.

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