CareSource

PHARMACY POLICY STATEMENT **Ohio Medicaid**	
DRUG NAME	Xeomin (incobotulinumtoxinA)
BILLING CODE	J0588
BENEFIT TYPE	Medical
SITE OF SERVICE ALLOWED	Office
COVERAGE REQUIREMENTS	Prior Authorization Required (Non-Preferred Product) QUANTITY LIMIT— see "Dosage Allowed"
LIST OF DIAGNOSES CONSIDERED **NOT** MEDICALLY NECESSARY	Click Here

Xeomin (incobotulinumtoxinA) is a **non-preferred** product and will only be considered for coverage under the **medical** benefit when the following criteria are met:

Members must be clinically diagnosed with one of the following disease states and meet their individual criteria as stated.

BLEPHAROSPASM

For **initial** authorization:

1. Member is 18 years of age or older; AND
2. Medication is prescribed by or in consultation with a neurologist or ophthalmologist; AND
3. Member has a diagnosis of blepharospasm, characterized by spasms inducing narrowing or closure of the eyelids.
4. **Dosage allowed:** Not to exceed 50 units per eye (100 units per treatment session) every 12 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:

1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. lessening of involuntary contraction).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CERVICAL DYSTONIA (SPASMODIC TORTICOLLIS)

For **initial** authorization:

1. Member is 18 years old or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has a documented diagnosis of moderate to severe cervical dystonia as evidenced by involuntary contractions of neck muscles, leading to abnormal movements or postures; AND
4. Symptoms affect quality of life and daily functions.
5. **Dosage allowed:** Up to 120 units every 12 weeks, divided among affected muscles.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. severity of abnormal head position, neck pain).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CHRONIC SIALORRHEA

For **initial** authorization:
1. Member is 18 years of age or older; AND
2. Medication must be prescribed by or in consultation with a neurologist; AND
3. Member has diagnosis of chronic sialorrhea impacting quality of life for at least 3 months; AND
4. Member has tried and failed or has a contraindication to at least TWO anticholinergic drugs (e.g. scopolamine, benztropine, glycopyrrolate, amitriptyline); AND
5. **Dosage allowed:** The recommended total dose is 100 Units per treatment session consisting of 30 Units per parotid gland and 20 Units per submandibular gland. (May repeat after no fewer than 16 weeks).

If member meets all the requirements listed above, the medication will be approved for 16 weeks.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes have been provided that show the member has shown improvement of signs and symptoms of disease.

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

SPASTICITY (upper limb only)

For **initial** authorization:
1. Member is 2 years of age or older; AND
2. Medication is prescribed by or in consultation with a neurologist; AND
3. Member has a documented diagnosis of UPPER limb spasticity that affects daily functioning and quality of life; AND
4. Spasticity is secondary to a neurologic condition such as stroke, or brain or spinal cord injury; AND
5. Member has tried or is unable to try a conservative treatment approach such as physical therapy or oral medication (e.g. baclofen, tizanidine).
6. **Dosage allowed:** (adult and pediatric) Maximum of 400 units per treatment session, every 12 weeks.

If member meets all the requirements listed above, the medication will be approved for 6 months.

For **reauthorization**:
1. Member must be in compliance with all other initial criteria; AND
2. Chart notes show improved signs and symptoms (e.g. decrease in severity of increased muscle tone).

If member meets all the reauthorization requirements above, the medication will be approved for an additional 12 months.

CareSource considers Xeomin (incobotulinumtoxinA) not medically necessary for the treatment of the diseases that are not listed in this document.

DATE	ACTION/DESCRIPTION
08/06/2018	New policy for Xeomin created. Age requirement removed for diagnoses of Cervical Dystonia and Upper Limb Spasticity. Criterion “no infection at proposed injection site” removed from Cervical Dystonia diagnosis; pain and abnormal head position requirements clarified and medications trial added. For Upper Limb Spasticity Ashworth scale requirement removed, post-stroke requirement and chart notes requirement of abnormal muscle tone documentation added.
04/05/2019	New indication of Chronic Sialorrhea added. Dose allowance increased for diagnosis of Cervical Dystonia. Trial of Botox removed form diagnosis of Blepharospasm.
06/09/2020	Edited criteria for Chronic Sialorrhea to more closely align with Myobloc – simplified exclusion criteria and added trial of anticholinergics. Changed qty limit at top of document.
08/24/2020	Blepharospasm: Extend re-auth duration to 12 mo, added specialist, re-phrased dose, revised diagnostic phrasing. Added reference. Cervical dystonia: Added age limit and specialist requirement. Re-worded the diagnosis requirement. Removed trial of oral medication. Removed exclusions. Corrected the dose. Extended re-auth duration. Updated references. Spasticity: Added age and specialist. Added trial of conventional treatment. Extended initial auth duration. Corrected the dose. Added references. Label recently expanded to include pediatrics.

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