Medical and Behavioral Health Policy Activity

Policies Effective: August 30, 2021 Notification Posted: July 1, 2021

Policies Developed

- **Idecabtagene Vicleucel, II-252**

I. Idecabtagene vicleucel (Abecma®) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:
- Age 18 years or older; **AND**
- Diagnosis of multiple myeloma; **AND**
- Relapsed or refractory disease after four or more prior lines of therapy, including **ALL** of the following:
  - An immunomodulatory agent;
  - A proteasome inhibitor;
  - An anti-CD38 monoclonal antibody;

  AND
- Not previously treated with chimeric antigen receptor (CAR) T-cell therapy; **AND**
- No FDA labeled contraindications to idecabtagene vicleucel; **AND**
- Screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) infection and has begun therapy if appropriate; **AND**
- Does not have ANY of the following:
  - Central nervous system (CNS) involvement with myeloma;
  - History or presence of clinically relevant CNS pathology (e.g., stroke with CNS sequelae, dementia);
  - Left ventricular ejection fraction < 45%;
  - History of allogeneic hematopoietic stem cell transplantation;

  AND
- For commercial health plan members only, step therapy supplement criteria may apply for select conditions (see policy II-242: Step Therapy Supplement).

II. All other uses of idecabtagene vicleucel are considered **EXPERIMENTAL/INVESTIGATIVE** due to the lack of clinical evidence demonstrating an impact on improved health outcomes.

Table. FDA-Labeled Contraindications

Agent	FDA Labeled Contraindications
Idecabtagene vicleucel	None

Documentation Submission:

Documentation supporting the medical necessity criteria described in the policy must be included in the prior authorization, when prior authorization is required. In addition, the following documentation must also be submitted:

1. Clinical notes describing the diagnosis and clinical features of the diagnosis.
2. Laboratory results for HBV, HCV, and HIV screening.
3. Clinical notes describing current and past treatments for the diagnosis, including response to the treatments.
4. Clinical notes documenting absence of central nervous system (CNS) involvement with myeloma, history or presence of clinically relevant CNS pathology (e.g., stroke with CNS sequelae, dementia); left ventricular ejection fraction < 45%, and history of allogeneic hematopoietic stem cell transplantation.
5. For commercial health plan members only, when step therapy requirements apply for the requested indication, documentation for one or more of the step therapy supplement criteria MUST be provided (see policy II-242).

Policies Revised

- **Transcatheter Mitral Valve Repair, IV-152**

I. <u>Transcatheter Mitral Valve Repair (TMVR) for Primary (Degenerative) Mitral Valve Regurgitation</u>

Transcatheter mitral valve repair (TMVR) with an FDA-approved device may be considered **MEDICALLY NECESSARY AND APPROPRIATE** as a treatment for **primary** mitral valve regurgitation when **ALL** of the following criteria are met:

- Performed via an approach consistent with the device's FDA-approved labeling; **AND**
- Severe mitral regurgitation (i.e., MR ≥ 3+) due to primary abnormality of the mitral apparatus (primary/degenerative MR); **AND**
- New York Heart Association (NYHA) heart failure Class III or IV symptoms; **AND**
- Prohibitive risk for open surgery including BOTH of the following:
  - Surgical risk judged by at least two cardiovascular specialists (cardiologist and cardiac surgeon/interventional cardiologist); AND
  - Risk score indicating prohibitive surgical risk as defined by EITHER:
    - Society for Thoracic Surgeons (STS) predicted mortality risk of 12% or greater; or
    - EuroSCORE II of 20% or greater;

  AND
- NONE of the following intolerances or contraindications:
  - Procedural anticoagulation; or
  - Post procedural antiplatelet regimen;

  AND
- Existing comorbidities do not preclude the expected benefit from reduction of the mitral valve regurgitation; **AND**
- TMVR is performed by a cardiac surgeon/interventional cardiologist experienced in performing percutaneous approaches to structural heart disease.

II. <u>Transcatheter Mitral Valve Repair (TMVR) for Secondary (Functional) Mitral Valve Regurgitation</u>

Transcatheter mitral valve repair (TMVR) with an FDA-approved device may be considered **MEDICALLY NECESSARY AND APPROPRIATE** as a treatment for **secondary/functional** mitral valve regurgitation when **ALL** of the following criteria are met:

- Moderate-to-severe mitral regurgitation (MR ≥ 3+) due to secondary/functional abnormality of the mitral apparatus; **AND**
- New York Heart Association (NYHA) heart failure Class II, III or IVa (ambulatory) symptoms despite maximally tolerated medical therapy including:
  - ALL of the following:
    - Angiotensin converting enzyme inhibitors (ACE inhibitor), angiotensin II receptor blocker (ARB), or angiotensin receptor-neprilysin inhibitor (ARNI); and
    - Beta blocker and mineralocorticoid receptor antagonist (e.g., spironolactone and eplerenone); and
    - Diuretic therapy if needed to treat volume overload;

    OR
  - Documented intolerance, FDA labeled contraindication, or hypersensitivity to guideline-based therapeutic agents:

  AND
- Left ventricular ejection fraction (LVEF) 20% - 50%; **AND**
- Left ventricular dilation (left ventricular end-systolic diameter [LVESD]) ≤ 70 mm; **AND**
- Pulmonary artery systolic pressure (PASP) ≤ 70 mm Hg; **AND**
- NONE of the following intolerances or contraindications:
  - Procedural anticoagulation; or
  - Post procedural antiplatelet regimen;

  AND
- Existing comorbidities do not preclude the expected benefit from reduction of the mitral valve regurgitation;

AND

- TMVR is performed by a cardiac surgeon/interventional cardiologist experienced in performing percutaneous approaches to structural heart disease.

III. Experimental / Investigative Uses

Transcatheter mitral valve repair is considered **EXPERIMENTAL/INVESTIGATIVE** for all other indications due to lack of clinical evidence demonstrating an impact on improved health outcomes.

Documentation Submission:

Documentation supporting the medical necessity criteria described in the policy must be included in the prior authorization, when prior authorization is required. In addition, the following documentation must also be submitted: Clinical notes describing the following:

1. Specific valve repair system to be used and approach planned (e.g. transfemoral); AND
2. Mitral regurgitation severity measurement; AND
3. New York Heart Association (NYHA) heart failure classification; AND
4. Documentation identifying primary or secondary cause of mitral valve regurgitation; AND
5. Attestation from cardiac surgeon/interventional cardiologist describing personal experience in performing percutaneous approaches to structural heart disease management (e.g., performs ≥ 50 structural procedures per year including atrial septal defects (ASD), patent foramen ovale (PFO) and trans-septal punctures); AND
6. Documentation risk for open surgery from two cardiovascular specialists making this determination; AND
7. If regurgitation is primary, risk score indicating prohibitive surgical risk:
   - Either of the following scoring systems;
     - Society for Thoracic Surgeons (STS) predicted risk of mortality score (STS-PROM); or
     - EuroSCORE II; AND
   - Documentation risk for open surgery is from two cardiovascular specialists making this determination; AND
8. If regurgitation is secondary, measurements of the following:
   - Left ventricular ejection fraction (LVEF)
   - Left ventricular dilation (left ventricular end-systolic diameter
   - Pulmonary artery systolic pressure (PASP).

- **Transcatheter Pulmonary Valve Implantation, IV-155**

I. Transcatheter pulmonary valve implantation (PVI) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Use of FDA-approved device consistent with FDA-approved indications; **AND**
- Right ventricular outflow tract (RVOT) dysfunction with EITHER of the following clinical indications for intervention:
  - Moderate or greater pulmonary regurgitation (i.e., PR ≥3+) with or without bioprosthetic valve; or
  - Pulmonary stenosis with a mean RVOT gradient ≥35 mmHg with or without bioprosthetic valve;

  AND
- Transcatheter PVI is performed by a cardiac surgeon/interventional cardiologist experienced in performing percutaneous approaches to structural heart disease.

II. Transcatheter pulmonary valve implantation is considered **EXPERIMENTAL/INVESTIGATIVE** for all other indications due to a lack of clinical evidence demonstrating an impact on improved health outcomes.

- **Synthetic Cartilage Implants for Metatarsophalangeal Joint Disorders, IV-153**
  Use of metatarsophalangeal synthetic cartilage implants consisting of biocompatible molded hydrogel (e.g., Cartiva®) is considered **EXPERIMENTAL/INVESTIGATIVE** for all indications, including but not limited to treatment of articular cartilage damage, due to the lack of clinical evidence demonstrating an impact on improved health outcomes.

- **Axicabtagene Ciloleucel, II-187**

I. Axicabtagene ciloleucel (Yescarta®) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:
- Age 18 years or older; **AND**
- Diagnosis of ANY of the following non-Hodgkin lymphoma (NHL):
  - Diffuse large B-cell lymphoma (DLBCL) not otherwise specified; or
  - Primary mediastinal large B-cell lymphoma; or
  - High-grade B-cell lymphoma; or
  - Follicular lymphoma grade 1-2; or
  - DLBCL arising from follicular lymphoma (FL) (i.e., transformed FL); or
  - DLBCL arising from nodal marginal zone lymphoma; or
  - AIDS-related DLBCL; or
  - Human herpesvirus 8 (HHV8)-positive DLBCL, not otherwise specified; or
  - Monomorphic post-transplant lymphoproliferative disorder (B-cell type);

  AND
- Disease is refractory or relapsed after TWO or more lines of systemic therapy. Examples include the following:
  - No response to last line of therapy, defined by progressive disease as best response to most recent therapy regimen; or
  - No response to last line of therapy, defined by stable disease as best response to most recent therapy with duration ≤6 months from last dose of therapy; or
  - Disease progression or relapsed ≤12 months post-autologous stem cell transplantation (ASCT); or
  - If salvage therapy is given post-ASCT, no response to or relapsed after the last line of therapy;

  AND
- Patient must have received adequate prior therapy, including ALL of the following:
  - Anti-CD20 monoclonal antibody (e.g., rituximab) unless tumor is CD20-negative; AND
  - An anthracycline-containing chemotherapy regimen, except for patients with follicular lymphoma; AND
  - For patients with transformed FL, prior chemotherapy for FL and chemorefractory disease after transformation to DLBCL;

  AND
- Not previously treated with chimeric antigen receptor (CAR) T-cell therapy; **AND**
- No FDA labeled contraindications to axicabtagene ciloleucel; **AND**
- Screened for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) infection; **AND**
- Does not have ANY of the following:
  - Active infection;
  - Inflammatory disorders;
  - Primary central nervous system lymphoma;
  - Active central nervous system involvement by malignancy;

  AND
- For commercial health plan members only, step therapy supplement criteria may apply for select conditions (see policy II-242: Step Therapy Supplement).

II. All other uses of axicabtagene ciloleucel are considered **EXPERIMENTAL/INVESTIGATIVE** due to the lack of clinical evidence demonstrating an impact on improved health outcomes.

Table. FDA-Labeled Contraindications

Agent	FDA-Labeled Contraindications
Axicabtagene ciloleucel	None

Documentation Submission:

Documentation supporting the medical necessity criteria described in the policy must be included in the prior authorization, when prior authorization is required. In addition, the following documentation must also be submitted:

1. Clinical notes describing the diagnosis and clinical features of the diagnosis.
2. Laboratory results for HBV, HCV, and HIV screening.
3. Clinical notes describing current and past treatments for the diagnosis, including response to the treatments.
4. Clinical notes documenting absence of active infection, inflammatory disorders, primary CNS lymphoma, and active central nervous system involvement by malignancy.
5. For commercial health plan members only, when step therapy requirements apply for the requested indication, documentation for one or more of the step therapy supplement criteria MUST be provided (see policy II-242).

- **Botulinum Toxin, II-16**

I. Abobotulinum Toxin A (Dysport®) Initial Review

Abobotulinum toxin A (Dysport®) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Diagnosis of ONE of the following:
  - Blepharospasm associated with dystonia, including benign essential blepharospasm or VII (facial) nerve disorders, in a patient 12 years of age or older; OR
  - Cervical dystonia (spasmodic torticollis; applicable whether congenital, due to childbirth injury, or traumatic injury) **AND** BOTH of the following:
    - Cervical dystonia must be associated with sustained head tilt or abnormal posturing with limited range of motion in the neck; AND
    - History of recurrent involuntary contraction(s) of one or more of the muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, or posterior cervical muscles); OR
  - Hemifacial spasm; OR
  - Spasticity associated with ONE of the following conditions:
    - Cerebral palsy; OR
    - Stroke; OR
  - Spasticity of the lower limb; OR
  - Spasticity of the upper limb;

  AND
- No FDA labeled contraindications to therapy (see table 1 below); **AND**
- Dose is within the FDA labeled dose for labeled indications or supported in literature for additional indications (see table 2 below).

II. Abobotulinum Toxin A (Dsyport®) Renewal Review

Abobotulinum toxin A (Dysport®) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Previously approved for therapy through the initial review process; AND

- Abobotulinum toxin A treatment has resulted in a reduction of symptom severity and/or frequency from baseline (prior to therapy); AND
- No FDA labeled contraindications to therapy (see table 1 below); AND
- Dose is within FDA labeled dose for labeled indications or supported in literature for additional indications (see table 2 below).

III. Incobotulinum Toxin A (Xeomin®) Initial Review

Incobotulinum toxin A (Xeomin®) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Diagnosis of ONE of the following:
  - Blepharospasm associated with dystonia, including benign essential blepharospasm or VII (facial) nerve disorders, in a patient 18 years of age or older ; OR
  - Cervical dystonia (spasmodic torticollis; applicable whether congenital, due to childbirth injury, or traumatic injury) **AND** BOTH of the following:
    - Cervical dystonia must be associated with sustained head tilt or abnormal posturing with limited range of motion in the neck; AND
    - History of recurrent involuntary contraction(s) of one or more of the muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, or posterior cervical muscles); OR
  - Spasticity of the upper limb; OR
  - Chronic sialorrhea **AND** ONE of the following:
    - Failed one conventional agent prerequisite (e.g., oral hyoscine, atropine drops, glycoprrolate, or amitriptyline); OR
    - Documented intolerance, FDA labeled contraindication, or hypersensitivity to at least one conventional agent;

  AND
- No FDA labeled contraindications to therapy (see table 1 below); **AND**
- Dose is within the FDA labeled dose for labeled indications (see table 2 below; **AND**
- For commercial health plan members only, step therapy supplement criteria may apply for select conditions (see policy II-242: Step Therapy Supplement).

IV. Incobotulinum Toxin A (Xeomin®) Renewal Review

Incobotulinum toxin A (Xeomin®) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Previously approved for therapy through the initial review process; **AND**
- Incobotulinum toxin A treatment has resulted in a reduction of symptom severity and/or frequency from baseline (prior to therapy); **AND**
- No FDA labeled contraindications to therapy (see table 1 below); **AND**
- Dose is within the FDA labeled dose for labeled indications (see table 2 below).

V. Onobotulinum Toxin A (Botox®) Initial Review

Onabotulinum toxin A (Botox®) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Diagnosis of ONE of the following:
  - Blepharospasm associated with dystonia, including benign essential blepharospasm or VII (facial) nerve disorders, in a patient 12 years of age or older; OR

- Cervical dystonia (spasmodic torticollis; applicable whether congenital, due to childbirth injury, or traumatic injury) **AND** BOTH of the following:
  - Cervical dystonia must be associated with sustained head tilt or abnormal posturing with limited range of motion in the neck; AND
  - History of recurrent involuntary contraction(s) of one or more of the muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, or posterior cervical muscles); OR
- Chronic anal fissures **AND** the following:
  - Failed one conventional therapy (e.g., bulking agents, sitz baths, laxatives, dietary changes, or 0.4% intra-anal nitroglycerin); OR
- Chronic migraine headache in a patient 18 years of age or older **AND** ALL of the following:
  - ≥15 headache days per month for at least 3 months; **AND**
  - ≥8 migraine days per month for at least 3 months; **AND**
  - Medication overuse headache has been ruled out; **AND**
  - **ONE** of the following:
    - Tried and failed a conventional agent prerequisite from at least two of the following migraine prophylaxis classes;
      - antidepressants (e.g., amitriptyline, venlafaxine);
      - calcium channel or beta blockers (e.g., propranolol, metoprolol, bisoprolol, verapamil);
      - anticonvulsants (e.g., topiramate, valproic acid);
      - self-administered calcitonin gene-related peptides (CGRPs) (i.e., erenumab [Aimovig], galcanezumab [Emgality]);

      OR
    - Documented intolerance, FDA labeled contraindication, or hypersensitivity to conventional agents from at least two of the following migraine prophylaxis classes;
      - antidepressants (e.g., amitriptyline, venlafaxine);
      - calcium channel or beta blockers (e.g., propranolol, metoprolol, bisoprolol, verapamil);
      - anticonvulsants (e.g., topiramate, valproic acid);
      - self-administered calcitonin gene-related peptides (CGRPs) (i.e., erenumab [Aimovig], galcanezumab [Emgality]);

    AND
  - Used for migraine prophylaxis; **AND**
  - Not used in combination with a CGRP agent for migraine prophylaxis; **AND**
  - Prescribed by or in consultation with a headache specialist (e.g., neurologist, pain management specialist, or specialist with United Council for Neurologic Subspecialities [UCNS] certification); OR
- Dystonia associated with ONE of the following conditions:
  - Focal upper limb dystonia (e.g., organic writer's cramp); OR
  - Oromandibular dystonia (e.g., orofacial dyskinesia, jaw-closing dystonia, Meige syndrome); OR
  - Laryngeal dystonia (adductor spasmodic dysphonia); OR
  - Idiopathic (primary or genetic) torsion dystonia; OR
  - Symptomatic (acquired) torsion dystonia; OR
- Esophageal achalasia **AND** ONE of the following:
  - Failed to respond to pneumatic dilation or myotomy; OR
  - Not a good candidate for pneumatic dilation or myotomy; OR
- Facial synkinesis; OR
- Hemifacial spasm; OR
- Neurogenic detrusor overactivity (NDA) in pediatric patients 5 years of age **AND ONE** of the following:
  - Failed two conventional agent prerequisites, including one anticholinergic agent (e.g., oxybutynin), AND mirabegron; OR
  - Documented intolerance, FDA labeled contraindication, or hypersensitivity to at least one anticholinergic agent AND mirabegron; OR
- Overactive bladder **AND** ALL of the following:

- Symptoms of urge urinary incontinence, urgency, and frequency; AND
- Conservative therapies including bladder training, pelvic floor muscle exercises, and fluid management have been inadequate; AND
- ONE of the following:
  - Failed two conventional agent prerequisites, including one anticholinergic agent (e.g., oxybutynin, tolterodine, trospium, darifenacin, solifenacin, or fesoterodine) AND mirabegron; OR
  - Documented intolerance, FDA labeled contraindication, or hypersensitivity to at least one anticholinergic agent AND mirabegron. OR

- Palmar or axillary hyperhidrosis **AND** ONE of the following:
  - Failed aluminum chloride 20% solution; OR
  - Documented intolerance, FDA labeled contraindication, or hypersensitivity to aluminum chloride 20% solution; OR
- Sialorrhea **AND** ONE of the following:
  - Failed one conventional agent prerequisite (e.g., oral hyoscine, atropine drops, glycoprrolate, or amitriptyline); OR
  - Documented intolerance, FDA labeled contraindication, or hypersensitivity to at least one conventional agent; OR
- Spasticity associated with ONE of the following conditions:
  - Cerebral palsy; OR
  - Stroke; OR
  - Acquired spinal cord or traumatic brain injury; OR
  - Hereditary spastic paraplegia; OR
  - Spastic hemiplegia; OR
  - Neuromyelitis optica; OR
  - Multiple sclerosis; OR
  - Schilder's disease; OR
- Spasticity of the lower limb; OR
- Spasticity of the upper limb; OR
- Strabismus, including persistent cranial VI nerve palsy of one month or longer, in a patient 12 years of age or older **AND** ALL of the following:
  - Inadequate response to corrective lenses; AND
  - Inadequate response to any other additional, patient appropriate, conservative corrective therapies (e.g., exercises); AND
  - Good vision in both eyes; AND
  - Eye movements are not restricted; AND
  - Small to moderate angle of esotropia; AND
  - Potential for the patient to experience binocular vision; OR
- Urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis) **AND** ONE of the following:
  - Failed two conventional agent prerequisites, including one anticholinergic agent (e.g., oxybutynin, tolterodine, trospium, darifenacin, solifenacin, or fesoterodine) AND mirabegron; OR
  - Documented intolerance, FDA labeled contraindication, or hypersensitivity to at least one anticholinergic agent AND mirabegron;

AND

- No FDA labeled contraindications to therapy (see table 1 below); **AND**
- Dose is within the FDA labeled dose for labeled indications or supported in literature for additional indications (see table 2 below); **AND**
- For commercial health plan members only, step therapy supplement criteria may apply for select conditions (see policy II-242: Step Therapy Supplement).

VI. Onobotulinum Toxin A (Botox®) Renewal Review

Onabotulinum toxin A (Botox®) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Previously approved for therapy through the initial review process; **AND**
- ONE of the following:
  - Diagnosis of chronic migraine headache **AND** ALL of the following:
    - ≥50% reduction in headache or migraine days per month from baseline (prior to therapy); **AND**
    - Used for migraine prophylaxis; **AND**
    - Not used in combination with a CGRP agent for migraine prophylaxis; **AND**
    - Prescribed by or in consultation with a headache specialist (e.g., neurologist, pain management specialist, or specialist with United Council for Neurologic Subspecialties [UCNS] certification); OR
  - Another diagnosis AND reduction of symptom severity and/or frequency from baseline (prior to therapy);

  AND
- No FDA labeled contraindications to therapy (see table 1 below); **AND**
- Dose is within the FDA labeled dose for labeled indications or supported in literature for additional indication (see table 2 below).

VII. Rimabotulinum Toxin B (Myobloc®) Initial Review

Rimabotulinum toxin B (Myobloc®) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Diagnosis of ONE of the following:
  - Cervical dystonia (spasmodic torticollis; applicable whether congenital, due to childbirth injury, or traumatic injury) **AND** BOTH of the following:
    - Cervical dystonia must be associated with sustained head tilt or abnormal posturing with limited range of motion in the neck; AND
    - History of recurrent involuntary contraction(s) of one or more of the muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, or posterior cervical muscles); OR
  - Chronic sialorrhea **AND** ONE of the following:
    - Failed one conventional agent prerequisite (e.g., oral hyoscine, atropine drops, glycoprrolate, or amitriptyline); OR
    - Documented intolerance, FDA labeled contraindication, or hypersensitivity to at least one conventional agent;

  AND
- No FDA labeled contraindications to therapy (see table 1 below); **AND**
- Dose is within the FDA labeled dose for labeled indications or supported in literature for additional indications (see table 2 below); **AND**
- For commercial health plan members only, step therapy supplement criteria may apply for select conditions (see policy II-242: Step Therapy Supplement).

VIII. Rimabotulinum Toxin B (Myobloc®) Renewal Review

Rimabotulinum toxin B (Myobloc®) may be considered **MEDICALLY NECESSARY AND APPROPRIATE** when **ALL** of the following criteria are met:

- Previously approved for therapy through the initial review process; **AND**
- Rimabotulinum toxin B treatment has resulted in a reduction of symptom severity and/or frequency from baseline (prior to therapy); **AND**
- No FDA labeled contraindications to therapy (see table 1 below); **AND**

- Dose is within the FDA labeled dose for labeled indications or supported in literature for additional indications (see table 2 below).

IX. Cosmetic Indications

The use of abobotulinum toxin A, incobotulinum toxin A, onabotulinum toxin A, or rimabotulinum toxin B is considered **COSMETIC** for the treatment of glabellar lines or wrinkles and other indications solely to improve appearance.

X. Experimental/Investigative Indications

All other uses of abobotulinum toxin A, incobotulinum toxin A, onabotulinum toxin A, or rimabotulinum toxin B are considered **EXPERIMENTAL/INVESTIGATIVE**, including but not limited to the following conditions, due to the lack of clinical evidence demonstrating an impact on improved health outcomes:

- Bell's palsy
- Benign prostatic hyperplasia
- Chronic low back pain
- Chronic motor tic disorder, and tics associated with Tourette syndrome (motor tics)
- Depressive disorders
- Detrusor sphincteric dyssynergia
- Essential tremor
- Facial wound healing
- Gastroparesis
- Headaches, except as noted above for chronic migraine headache
- Hirschsprung's disease
- Internal anal sphincter (IAS) achalasia
- Interstitial cystitis
- Joint pain
- Lateral epicondylitis
- Mechanical neck disorders
- Myofascial pain syndrome
- Neuropathic pain after neck dissection
- Pain after hemorrhoidectomy or lumpectomy
- Prevention of pain associated with breast reconstruction after mastectomy
- Raynaud's disease/Raynaud's phenomenon
- Tinnitus
- Trigeminal neuralgia

Table 1. FDA Labeled Contraindications

Agent	FDA Labeled Contraindications
Abobotulinum toxin A (Dysport®)	Hypersensitivity; Allergy to cow's milk protein; Infection at the proposed injection site(s)

Incobotulinum toxin A (Xeomin®)	Hypersensitivity; Infection at the proposed injection sites
Onabotulinum toxin A (Botox®)	Hypersensitivity; Infection at the proposed injection site; For intradetrusor injections, urinary tract infection or urinary retention
Rimabotulinum toxin B (Myobloc®)	Hypersensitivity; Infection at the proposed injection site(s)

Table 2. Dosing

Onabotulinum Toxin A (Botox) Dosing

For one or more indications, unless otherwise stated below, the maximum cumulative dose for onobutulinum toxin A (Botox®) is 400 units every 12 weeks.

FDA Labeled Indications	Maximum Treatment Dose	Minimum Dosing Interval
Blepharospasm	Initial: 15 units (2.5 units into each of 3 sites per affected eye) Retreatment: 30 units (5 units into each of 3 sites per affected eye). Cumulative dose in 30 days should not exceed 200 units.	Every 12 weeks
Cervical dystonia	300 units divided among affected muscles	Every 12 weeks
Primary axillary hyperhidrosis	100 units (50 units per axilla)	Every 12 weeks
Chronic migraine prophylaxis	155 units divided across specific head/neck muscle areas	Every 12 weeks
Pediatric (> age 5) Detrusor overactivity associated with a neurologic condition	Wt ≥ 34 kg: 200 units as intradetrusor injection Wt < 34 kg: 6 Units/kg body weight administered as a bladder injection	Every 12 weeks
Detrusor overactivity associated with a neurologic condition	200 units	Every 12 weeks
Overactive bladder	100 units	Every 12 weeks
Strabismus	Initial: 5 units per muscle	Every 12 weeks

	Retreatment: 25 units per muscle	
Spasticity	400 units divided among affected muscles	Every 12 weeks
Off-Label Indications		
Achalasia	100 units (25 units per quadrant)	Every 6 months
Chronic anal fissure	25 units	Every 12 weeks
Facial synkinesis	100 units divided among affected muscles	Every 12 weeks
Focal limb dystonia	20 units divided among affected muscles	Every 12 weeks
Laryngeal dystonia (spasmodic dysphonia)	25 units	Every 12 weeks
Oromandibular dystonia	100 units per muscle	Every 12 weeks
Sialorrhea	260 units (100 units per parotid gland and 30 units per submandibular gland)	Every 12 weeks
Torsion dystonia	140 units	Every 12 weeks
Hemifacial spasm	25 units divided among affected muscles	Every 12 weeks
Primary palmar hyperhidrosis	100 units (50 units per palm)	Every 12 weeks

Abobotulinum Toxin A (Dysport) Dosing

For one or more indications, unless otherwise stated below, the maximum cumulative dose for abobotulinum toxin A (Dysport®) is 1,000 units every 12 weeks.

FDA Labeled Indications	Maximum Treatment Dose	Minimum Dosing Interval
Cervical dystonia	Initial: 500 units divided among affected muscles Retreatment: 1,000 units divided among affected muscles	Every 12 weeks
Spasticity in adults	1,500 units divided among affected muscles	Every 12 weeks

Spasticity in pediatric patients	30 units/kg or 1,000 units, whichever is lower, divided among affected muscles	Every 12 weeks
Off-Label Indications		
Blepharospasm	240 units (120 units per eye)	Every 12 weeks
Hemifacial spasm	220 units divided among affected muscles	Every 12 weeks

Rimabotulinum Toxin B (Myobloc) Dosing

For one or more indications, unless otherwise stated below, the maximum cumulative dose for rimabotulinum toxin B (Myobloc®) is 10,000 every 12 weeks.

FDA Labeled Indications	Maximum Treatment Dose	Minimum Dosing Interval
Cervical dystonia	Initial: 5,000 units divided among affected muscles Retreatment: 10,000 units divided among affected muscles	Every 12 weeks
Off-Label Indications		
Sialorrhea	2,500 units (1,000 units per parotid gland and 250 units per submandibular gland)	Every 12 weeks

Incobotulinum Toxin A (Xeomin) Dosing

For one or more indications, unless otherwise stated below, the maximum cumulative dose for incobotulinum toxin A (Xeomin®) is 400 units every 12 weeks.

FDA Labeled Indications	Maximum Treatment Dose	Minimum Dosing Interval
Blepharospasm	100 units (50 units per eye)	Every 12 weeks
Cervical dystonia	120 units divided among affected muscles	Every 12 weeks
Upper limb spasticity	400 units (both limbs) divided among affected muscles	Every 12 weeks
Chronic Sialorrhea in adults	100 units divided with a ratio of 3:2 between parotid and submandibular glands	Every 16 weeks
Chronic Sialorrhea in pediatric patients	20 – 75 total units across both sides of face and both the parotid glands and submandibular glands, dosed according to body weight class per FDA label. Total dose should be divided with a ratio of 3:2	Every 16 weeks

	between the parotid and submandibular glands with total 4 injection sites per treatment session.	

Documentation Submission:
Documentation supporting the medical necessity criteria described in the policy must be included in the prior authorization, when prior authorization is required. In addition, the following documentation must also be submitted:

Initial Review

1. Clinical notes describing the diagnosis and clinical features of the diagnosis.
2. Clinical notes describing current and past treatments for the diagnosis, including response to the treatments. For onabotulinum toxin A (Botox®) requests to treat chronic migraine headache, clinical notes should include evaluation for potential medication overuse headache.
3. The dose being requested, including the patient's weight if the requested botulinum toxin agent and diagnosis require weight-based dosing. If the requested dose is higher or more frequent than the dosing guidelines provided above, a clear explanation for the medical necessity of the requested dose MUST be submitted, including prior dosing (strength and frequency) associated with inadequate response.
4. For commercial health plan members only, when step therapy requirements apply for the requested indication, documentation for one or more of the step therapy supplement criteria MUST be provided (see policy II-242).

Renewal Review

1. Documentation of prior approval for the requested botulinum toxin agent through the initial review process.
2. Documentation supporting reduction of symptom severity and/or frequency from baseline. For onabotulinum toxin A (Botox®) requests to treat chronic migraine headache, include information from the medical record and/or headache diary/log entries quantifying a reduction in migraine frequency or duration compared to baseline.
3. Clinical notes describing current and past treatments for the diagnosis, including response to the treatments.
4. The dose being requested, including the patient's weight if the requested botulinum toxin agent and diagnosis require weight-based dosing. If the requested dose is higher or more frequent than the dosing guidelines provided above, a clear explanation for the medical necessity of the requested dose MUST be submitted, including prior dosing (strength and frequency) associated with inadequate response.

Policies Delegated to eviCore
None

Policies Inactivated
None