Health Alliance™ Pharmacy Drug Policy Checklist

POLICY NAME	Xeomin (incobotulinumtoxin A)	POLICY #	2377P

Criteria

Criteria for Coverage for Cervical Dystonia

- ☐ Alternative diagnoses ruled out including chronic neuroleptic treatment, contractures, and other neuromuscular disorders
- ☐ Involuntary contractions of the neck muscles
- ☐ Chronic head torsion or tilt
- ☐ Symptoms present for at least 6 months
- ☐ Approval Time
  - Initial Approval: 4 procedures, repeated no more frequently than every 12 weeks within 12 months
  - Subsequent Approvals: 4 procedures, repeated no more frequently than every 12 weeks

Criteria for Coverage for Blepharospasm

- ☐ Previous treatment with Botox
- ☐ Approval Time
  - Initial Approval: 4 procedures, repeated no more frequently than every 12 weeks within 12 months
  - Subsequent Approvals: 4 procedures, repeated no more frequently than every 12 weeks

Criteria for Coverage for Upper Limb Spasticity

- ☐ Documented focal wrist, elbow, or finger spasticity which originated at least 6 weeks post-cerebrovascular event (CVE) or progression of multiple sclerosis
- ☐ Difficulty maintaining hygiene, dressing or pain
- ☐ Documented failure, intolerance, or contraindication to oral antispasmodics and muscle relaxants;
  - Baclofen
  - Tizanidine
  - Cyclobenzaprine
  - Methocarbamol
  - Carisoprodol

- [ ] Sufficient motivation and cognitive function to actively participate in physical therapy post injection
- [ ] No documented fixed contractures or profound muscle atrophy
- [ ] Member will not receive treatment with phenol, alcohol, or surgery
- [ ] Approval Time
  - Initial Approval: 4 procedures, repeated no more frequently than every 12 weeks within 12 months
  - Subsequent Approvals: 4 procedures, repeated no more frequently than every 12 weeks

Coverage for Sialorrhea

- [ ] Age 2 years or older
- [ ] Documented diagnosis of one of the following:
  - Parkinson's Disease
  - Amyotrophic Lateral Sclerosis (ALS) Criteria Statement of the Policy References
  - Cerebral Palsy
  - Stroke
- [ ] Documented failure or intolerance to one of the following therapies:
  - Glycopyrrolate
  - Amitriptyline
  - Hyoscyamine
  - Sublingual ipratropium
  - Sublingual atropine
- [ ] Approval Time
  - Initial Approval: 4 procedures, repeated no more frequently than every 12 weeks within 12 months
  - Subsequent Approvals: 4 procedures, repeated no more frequently than every 12 weeks CPT Codes HCPCS Codes J0588 Injection, incobotulinumtoxin A [Xeomin]