Pharmacy Drug Policy Checklist

POLICY NAME	Xeomin (incobotulinumtoxin A)	POLICY #	2377P

Criteria

Criteria for Coverage for Cervical Dystonia

- ☐ **1.1** Alternative diagnoses ruled out including chronic neuroleptic treatment, contractures, and other neuromuscular disorders
- ☐ **1.2** Involuntary contractions of the neck muscles
- ☐ **1.3** Chronic head torsion or tilt
- ☐ **1.4** Symptoms present for at least 6 months
- ☐ **1.5** 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

- ☐ **2.1** Previous treatment with Botox
- ☐ **2.2** 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

- ☐ **3.1** Documented focal wrist, elbow, or finger spasticity which originated at least 6 weeks post-cerebrovascular event (CVE) or progression of multiple sclerosis
- ☐ **3.2** Difficulty maintaining hygiene, dressing or pain
- ☐ **3.3** Documented failure, intolerance, or contraindication to oral antispasmodics and muscle relaxants;
  - Baclofen
  - Tizanidine
  - Cyclobenzaprine
  - Methocarbamol
  - Carisoprodol
- ☐ **3.4** Sufficient motivation and cognitive function to actively participate in physical therapy post injection
- ☐ **3.5** No documented fixed contractures or profound muscle atrophy
- ☐ **3.6** Member will not receive treatment with phenol, alcohol, or surgery
- ☐ **3.7** 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

- ☐ **4.1** Age 2 years or older
- ☐ **4.2** Documented diagnosis of one of the following:
  - Parkinson's Disease
  - Amyotrophic Lateral Sclerosis (ALS) Criteria Statement of the Policy References
  - Cerebral Palsy
  - Stroke
- ☐ **4.3** Documented failure or intolerance to one of the following therapies:
  - Glycopyrrolate
  - Amitriptyline
  - Hyoscyamine
  - Sublingual ipratropium
  - Sublingual atropine
- ☐ **4.4** 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]