

Clinical Policy: IncobotulinumtoxinA (Xeomin)

Reference Number: CP.PHAR.231

Effective Date: 07.01.16

Last Review Date: 05.20

Line of Business: Commercial, HIM, Medicaid

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

IncobotulinumtoxinA (Xeomin[®]) is an acetylcholine release inhibitor and a neuromuscular blocking agent.

FDA Approved Indication(s)

Xeomin is indicated

- For treatment or improvement of adult patients with:
 - Chronic sialorrhea
 - Upper limb spasticity
 - Cervical dystonia (CD)
 - Blepharospasm
- For temporary improvement in the appearance of moderate to severe glabellar lines associated with corrugator and/or procerus muscle activity in adult patients

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

I. Initial Approval Criteria

A. Chronic Sialorrhea (must meet all):

1. Diagnosis of chronic sialorrhea for at least the last three months due to one of the following (a or b):
 - a. Underlying neurologic disorder (e.g., Parkinson disease, atypical parkinsonism, stroke, traumatic brain injury, cerebral palsy, amyotrophic lateral sclerosis);
 - b. Craniofacial abnormality (e.g., Goldenhar syndrome);
2. Prescribed by or in consultation with a neurologist or physiatrist;
3. Age \geq 18 years;
4. Failure of at least one anticholinergic drug (*see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;
5. Member meets both of the following (a and b):
 - a. Xeomin is not prescribed concurrently with other botulinum toxin products;
 - b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 16 weeks;
6. Treatment plan details number of Units per injection site and treatment session;

7. Dose does not exceed 30 Units per parotid gland, 20 Units per submandibular gland, 100 Units per treatment session.

Approval duration:

Medicaid/HIM – 16 weeks (single treatment session)

Commercial – 6 months

B. Upper Limb Spasticity (must meet all):

1. Diagnosis of upper limb spasticity;
2. Prescribed by or in consultation with a neurologist, orthopedist, or physiatrist;
3. Age \geq 18 years;
4. Member meets both of the following (a and b):
 - a. Xeomin is not prescribed concurrently with other botulinum toxin products;
 - b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
5. Treatment plan details number of Units per injection site and treatment session;
6. Dose does not exceed 400 Units per treatment session.

Approval duration:

Medicaid/HIM – 12 weeks (single treatment session)

Commercial – 6 months

C. Cervical Dystonia (must meet all):

1. Diagnosis of CD;
2. Prescribed by or in consultation with a neurologist, orthopedist, or physiatrist;
3. Age \geq 18 years;
4. Member is experiencing involuntary contractions of the neck and shoulder muscles (e.g., splenius, sternocleidomastoid, levator scapulae, scalene, trapezius, semispinalis capitis) resulting in abnormal postures or movements of the neck, shoulder or head;
5. Contractions are causing pain and functional impairment;
6. Member meets both of the following (a and b):
 - a. Xeomin is not prescribed concurrently with other botulinum toxin products;
 - b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
7. Treatment plan details number of Units per injection site and treatment session;
8. Dose does not exceed 120 Units per treatment session.

Approval duration:

Medicaid/HIM – 12 weeks (single treatment session)

Commercial – 6 months

D. Blepharospasm (*a focal dystonia*) (must meet all):

1. Diagnosis of blepharospasm;
2. Prescribed by or in consultation with a neurologist or ophthalmologist;
3. Age \geq 18 years;
4. Member is experiencing significant disability in daily functional activities due to interference with vision;
5. Member meets both of the following (a and b):
 - a. Xeomin is not prescribed concurrently with other botulinum toxin products;

- b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
- 6. Treatment plan details number of Units per injection site and treatment session;
- 7. Dose does not exceed 25 Units per eye per treatment session.

Approval duration:

Medicaid/HIM – 12 weeks (single treatment session)

Commercial – 6 months

E. Other diagnoses/indications

- 1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Approval

A. All Indications in Section I (must meet all):

- 1. Currently receiving medication via Centene benefit or member has previously met all initial approval criteria;
- 2. Member is responding positively to therapy;
- 3. Member meets both of the following (a and b):
 - a. Xeomin is not prescribed concurrently with other botulinum toxin products;
 - b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 week (16 weeks if sialorrhea);
- 4. If request is for a dose increase, new dose does not exceed the following indication-specific maximums (a, b, c, or d):
 - a. Chronic sialorrhea: 30 Units per parotid gland, 20 Units per submandibular gland, 100 Units per treatment session;
 - b. Upper limb spasticity: 400 Units per treatment session;
 - c. CD: 120 Units per treatment session;
 - d. Blepharospasm: 50 Units per eye per treatment session.

Approval duration:

Medicaid/HIM – 16 weeks for sialorrhea (single treatment session), 12 weeks for all other indications (single treatment session)

Commercial – 12 months

B. Other diagnoses/indications (must meet 1 or 2):

- 1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

Approval duration: Duration of request or 6 months (whichever is less); or

- 2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and 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.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents;
- B. Cosmetic treatment of hyperfunctional wrinkles of the upper face including glabellar frown lines, deep forehead wrinkles and periorbital wrinkles (crow’s feet).
- C. Same-visit treatment of multiple indications.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CD: cervical dystonia

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
glycopyrrolate (Glycate [®])	1 mg PO TID	6 mg/day
benztropine (Cogentin [®])	1 mg PO QD-BID	3.8 mg/day

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.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s):
 - Known hypersensitivity to the active substance botulinum neurotoxin type A or to any of the excipients.
 - Infection at the proposed injection sites.
- Boxed warning(s): Distant spread of toxin effect.

Appendix D: Botulinum Toxin Product Interchangeability

- Potency Units of Xeomin are not interchangeable with other botulinum toxin product preparations (e.g., Dysport[®], Botox[®], Myobloc[®]).

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Chronic sialorrhea	Up to 30 Units IM per parotid gland, 20 Units IM per submandibular gland, and 100 Units IM per treatment session every 16 weeks.	• 100 Units/16 weeks
CD	Up to 120 Units IM per treatment session every 12 weeks.	120 Units/12 weeks

Indication	Dosing Regimen	Maximum Dose
Blepharospasm	Up to 25 Units IM per eye per treatment session every 12 weeks.	100 Units/12 weeks
Upper limb spasticity	Up to 400 Units IM per treatment session every 12 weeks.	400 Units/12 weeks

VI. Product Availability

Vial: 50 Units, 100 Units, 200 Units

VII. References

1. Xeomin Prescribing Information. Frankfurt, Germany: Merz Pharmaceuticals, LLC; May 2019. Available at: <http://xeomin.com/wp-content/uploads/xeomin-full-prescribing-information.pdf>. Accessed February 12, 2020.

Sialorrhea

2. Seppi K, Chahine L, Chaudhuri R et al. International Parkinson and Movement Disorder Society evidence-based medicine review: Update on treatments for the non-motor symptoms of Parkinson's Disease. 2018. Available at <https://www.movementdisorders.org/MDS-Files1/Resources/PDFs/EBM-NMS-Final-Paper-August-2018.pdf>.
3. Sridharan K, Sivaramakrishnan G. Pharmacological interventions for treating sialorrhea associated with neurological disorders: A mixed treatment network meta-analysis of randomized controlled trials. *Journal of Clinical Neuroscience* 51 (2018) 12–17.
4. Lakraj AA, Moghimi, Jabbari B. Sialorrhea: Anatomy, pathophysiology and treatment with emphasis on the role of botulinum toxins. *Toxins* 2013, 5, 1010-1031; doi:10.3390/toxins5051010.
5. Young CA, Johnson EC, et al. Treatment for sialorrhea (excessive saliva) in people with motor neuron disease/amyotrophic lateral sclerosis. *Cochrane Database Syst Rev*. 2011 May 11;(5):CD006981. doi: 10.1002/14651858.CD006981.pub2.

Spasticity, Dystonia

6. Simpson DM, Hallett M, Ashman EJ et al. Practice guideline update summary: botulinum neurotoxin for the treatment of blepharospasm, cervical dystonia, adult spasticity, and headache: Report of the Guideline Development Subcommittee of the American Academy of Neurology. *Neurology*. 2016; 86(19): 1818-1826.
7. Simpson DM, Gracies JM, Graham HK et al. Assessment: botulinum neurotoxin for the treatment of spasticity (an evidence-based review): Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. *Neurology*. 2008; 70(19): 1691-1698.
8. Simpson DM, Blitzer A, Brashear A et al. Assessment: botulinum neurotoxin for the treatment of movement disorders (an evidence-based review): Report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. *Neurology*. 2008; 70: 1699-1706.
9. Albanese A, Bhatia K, Bressman SB, et al. Phenomenology and classification of dystonia: a consensus update. *Mov Disord*. June 15, 2013; 28(7): 863-873. doi:10.1002/mds.25475.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-

date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J0588	Injection, incobotulinumtoxinA, 1 unit

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.09. Created criteria for new indication of upper limb spasticity per FDA labeling. Added max dosing per FDA labeling. Added prescriber requirement. Removed reauthorization criteria requiring attestation of significant improvement in symptoms and/or health-related quality of life.	05.16	07.16
CD and upper limb spasticity are split into separate criteria sets. Added to CD a definition and requirement of pain and functional impairment. CD dose reduced from 400 to 120 units per treatment session per PI. Blepharospasm definition is added; “focal dystonia” parenthetical is added clarifying it as a dystonia. Added examples of muscle groups and an informational footnote to upper limb spasticity. Efficacy statement added under continuation criteria. Removed safety information. Dystonia information is added at Appendix B. “Non-cosmetic” parenthetical added to the background FDA indication section; cosmetic coverage restriction reworded under the “Other Diagnoses/Indications” section to include notation of glabellar lines.	06.17	07.17
2Q 2018 annual review: added physical medicine and rehabilitation specialist for cervical dystonia and upper limb spasticity; combined Medicaid and Commercial lines of business; added HIM; intent of therapy language removed from upper limb spasticity indication; Commercial: approval durations changed from length of benefit to 6 months initial and 12 months continued approval; references reviewed and updated.	04.24.18	05.18
Criteria added for new FDA indication: chronic sialorrhea; references reviewed and updated.	08.21.18	02.19
2Q 2019 annual review: no significant changes; references reviewed and updated.	02.05.19	05.19
Criteria updated for new FDA approved indication: first-line treatment for blepharospasms; references reviewed and updated.	06.25.19	11.19
Added requirement for trial of anticholinergic agents for chronic sialorrhea.	10.08.19	02.20
2Q 2020 annual review: HIM nonformulary language removed; sialorrhea medical trial added; rehabilitation specialist incorporated under psychiatrist; previous (last 12 weeks) or concurrent toxin	03.02.20	05.20

Reviews, Revisions, and Approvals	Date	P&T Approval Date
product use restriction added to all initial/continuation criteria; dosing updated per package insert; same-visit treatment for multiple indications is excluded (Section III); references reviewed and updated.		

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.

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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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