

Clinical Policy: IncobotulinumtoxinA (Xeomin)

Reference Number: CP.PHAR.231

Effective Date: 07.01.16

Last Review Date: 11.19

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 the treatment or improvement of adult patients with:

- Chronic sialorrhea
- Upper limb spasticity
- Cervical dystonia (CD)
- Blepharospasm
- 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 an underlying neurologic disorder or craniofacial abnormality (*see Appendix D*);
2. Prescribed by or in consultation with a neurologist, physiatrist, or physical medicine and rehabilitation specialist;
3. Age \geq 18 years;
4. Provider submits treatment plan detailing the quantity (in units) of Xeomin to be injected in each gland, anticipated frequency of injection(s), and total dose per visit;
5. Dose does not exceed 100 units per treatment session.

Approval duration:

Medicaid/HIM – 16 weeks (single treatment session)

Commercial – 6 months

B. Cervical Dystonia (must meet all):

1. Diagnosis of CD (*see Appendix E*);

2. Prescribed by or in consultation with a neurologist, orthopedist, physiatrist, or physical medicine and rehabilitation specialist;
3. Age \geq 18 years;
4. 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. Provider submits treatment plan detailing the quantity (in units) of Xeomin to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
7. Dose does not exceed 120 units per treatment session.

Approval duration:

Medicaid/HIM – 12 weeks (single treatment session)

Commercial – 6 months

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

1. Diagnosis of blepharospasm (i.e., abnormal contraction of eyelid muscles);
2. Prescribed by or in consultation with a neurologist or ophthalmologist;
3. Age \geq 18 years;
4. Member has significant disability in daily functional activities due to interference with vision;
5. Provider submits treatment plan detailing the quantity (in units) of Xeomin to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed 50 units per eye per treatment session.

Approval duration:

Medicaid/HIM – 12 weeks (single treatment session)

Commercial – 6 months

D. Upper Limb Spasticity (must meet all):

1. Diagnosis of upper limb spasticity;
2. Prescribed by or in consultation with a neurologist, orthopedist, physiatrist, or physical medicine and rehabilitation specialist;
3. Age \geq 18 years;
4. Provider submits treatment plan detailing the quantity (in units) of Xeomin to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
5. Dose does not exceed 400 units 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. It has been at least 12 weeks (16 weeks if sialorrhea) since the last injection of Xeomin;
4. Provider submits treatment plan detailing the quantity (in units) of Xeomin to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
5. If request is for a dose increase, new dose does not exceed the following indication-specific maximums (a or b):
 - a. Chronic sialorrhea: 100 units per treatment session;
 - b. CD: 120 units per treatment session;
 - c. Upper limb spasticity: 400 units per treatment session;
 - d. Blepharospasm: 50 units per eye per treatment session.

Approval duration:

Medicaid/HIM - 12 weeks, or 16 weeks if sialorrhea (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).

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CD: cervical dystonia

FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives
Not applicable

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: Examples of Neurologic Disorders and Craniofacial Abnormalities

- Neurologic disorders:
 - Parkinson disease, atypical parkinsonism, stroke, traumatic brain injury, cerebral palsy, amyotrophic lateral sclerosis
- Craniofacial abnormalities:
 - Goldenhar syndrome

Appendix E: Definition and Classification of Dystonia

- Dystonia is defined as a movement disorder characterized by sustained or intermittent muscle contractions causing abnormal, often repetitive, movements, postures, or both.
 - Dystonic movements are typically patterned and twisting, and may be tremulous.
 - Dystonia is often initiated or worsened by voluntary action and associated with overflow muscle activation.
- Dystonia is classified along two axes:
 - Clinical characteristics: Age at onset, body distribution, temporal pattern, associated features (additional movement disorders or neurological features) - *the clinical characteristics fall into several specific dystonia syndromes that help to guide diagnosis and treatment;*
 - Etiology: Nervous system pathology, inheritance.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Chronic sialorrhea	Xeomin is injected into the parotid and submandibular glands on both sides (i.e., 4 injection sites per treatment session). The recommended total dose per treatment session is 100 Units. The dose is divided with a ratio of 3:2 between the parotid and submandibular glands.	<ul style="list-style-type: none"> • One treatment period per 16 weeks • 100 units per treatment session • Parotid gland(s): 60 units (30 units per side) • Submandibular gland(s): 40 units (20 units per side)
CD	The usual starting dose is 120 units per treatment session, doses up to 300 units may be used in treatment-experienced patients. Dose, number, and location of injection sites should be based on the	120 units per treatment session

Indication	Dosing Regimen	Maximum Dose
	number and location of muscles involved, severity of dystonia, and response to any previous botulinum toxin injections.	
Blepharospasm	The recommended starting dose is 25 units per eye.	50 units per eye per treatment session
Upper limb spasticity	Dosing varies based on location of muscles to be treated (<i>refer to dosing chart in the prescribing information</i>).	400 units per treatment session

VI. Product Availability

Vials: 50 units, 100 units, 200 units

VII. References

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2. Botox Prescribing Information. Madison, NJ: Allergan USA, Inc.; September 2018. Available at http://www.allergan.com/assets/pdf/botox_pi.pdf. Accessed January 25, 2019.
3. Blitzer A, Freidman A, Michel O, et al. Efficacy and safety of incobotulinumtoxinA for the treatment of sialorrhea in Parkinson’s disease (PD) and other neurological conditions: Results of a Phase III, placebo-controlled, randomized, double-blind study. Poster presented at: MDS 2017 (21st International Congress of Parkinson’s Disease and Movement Disorders), June 4-8, 2017; Vancouver, BC, Canada. Full Text: [https://www.pmrjournal.org/article/S1934-1482\(17\)31266-2/fulltext](https://www.pmrjournal.org/article/S1934-1482(17)31266-2/fulltext) (Last accessed: 04 June, 2018.)
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11. 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.
12. 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.

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	04.24.18	05.18

Reviews, Revisions, and Approvals	Date	P&T Approval Date
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.		
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

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the non-formulary policy; HIM.PA.103.

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