Health Alliance™

Pharmacy Drug Policy & Procedure

Policy Name:	Xeomin (incobotulinumtoxin A)	Policy #:	2377P

Purpose of the Policy

The purpose of this policy is to establish the criteria for coverage of Xeomin (onabotulinumtoxin A).

Statement of the Policy

Health Alliance Medical Plans will approve the use of Xeomin under the general medical benefit when the following criteria have been met.

Criteria

1. 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

2. 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

3. 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

4. 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)

- 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]

References

1. Xeomin (incobotulinumtoxinA) [prescribing information] Raleigh, NC: Merz Pharmaceuticals LLC; September 2023.
2. Castelão M, Marques RE, Duarte GS, et al. Botulinum toxin type A therapy for cervical dystonia. Cochrane Database Syst Rev 2017; 12:363.
3. Jankovic J, Comella C, Hanschmann A, Grafe S. Efficacy and safety of incobotulinumtoxinA (NT 201, Xeomin) in the treatment of blepharospasm-A randomized trial. Mov Disord 2011; 26:1521.
4. 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; 86:1818.
5. Jost WH, Friedman A, Michel O, et al. SIAXI: Placebo-controlled, randomized, double-blind study of incobotulinumtoxinA for sialorrhea. Neurology 2019; 92:e1982.

Created Date: 08/05/15
Effective Date: 08/05/15
Posted to Website: 01/01/22
Revision Date: 08/07/24

DISCLAIMER
This Medical Policy has been developed as a guide for determining medical necessity. The process of medical necessity review also entails review of the most recent literature and physician review. Medical Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care. Health Alliance encourages input from providers when developing and implementing medical policies. Benefit determinations are based on applicable contract language in the member's Policy/ Subscription Certificate/ Summary Plan Description. This Medical Policy does not guarantee coverage. There may be a delay between the revision of this policy and the posting on the web. Please contact the Health Alliance Customer Service Department at 1-800-851-3379 for verification of coverage.