CarePartners of Connecticut MEDICARE ADVANTAGE

Medical Necessity Guidelines
Medical Benefit Drugs

# Myobloc® (rimabotulinumtoxin B)

*Effective: January 1, 2024*

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|---|---|
| **Guideline Type** | ☒ Prior Authorization<br>☐ Non-Formulary<br>☐ Step-Therapy<br>☐ Administrative |

**Applies to:**

☒ CarePartners of Connecticut Medicare Advantage HMO plans, Fax 617-673-0956
☒ CarePartners of Connecticut Medicare Advantage PPO plans, Fax 617-673-0956

**Note:** While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

## Overview

Botulinum toxins are potent neuromuscular blocking agents that are useful in treating various focal muscle spastic disorders and excessive muscle contractions, such as dystonias, spasms, and twitches. Although Botulinum toxins have only been Food and Drug Administration (FDA)-approved for limited uses, they are frequently used off-label as well. A patient who is not responsive or who ceases to respond to one botulinum toxin product may respond to another. Coverage criteria for Myobloc is based on Local Coverage Determination (LCD) Botulinum Toxins (L33646), and also includes Part B Step Therapy Policy requirements.

**Food and Drug Administration-Approved Indications**

**Myobloc (rimabotulinumtoxin B)** is an acetylcholine release inhibitor indicated for:

- Treatment of cervical dystonia to reduce the severity of abnormal head position and neck pain associated with cervical dystonia in adults
- Treatment of chronic sialorrhea in adults

Botox (onabotulinumtoxinA) and Xeomin (incobotulinumtoxinA) are the preferred botulinum toxin products.

## Clinical Guideline Coverage Criteria

The plan may authorize coverage of Myobloc for Members when the following criteria are met:

**Cervical dystonia**

1. Documented diagnosis of cervical dystonia

**AND**

2. The member is 18 years of age and older

**AND**

3. Documentation the requested medication is being prescribed to reduce the severity of abnormal head position and neck pain

**Chronic Sialorrhea**

1. Documented diagnosis of chronic sialorrhea

**AND**

2. The member is 18 years of age and older

**Cervical dystonia**

2. Documented diagnosis of cervical dystonia

**AND**

3. The member is 18 years of age and older

**AND**

4. Documentation the requested medication is being prescribed to reduce the severity of abnormal head position and neck pain

**Sialorrhea**

2. Documented diagnosis of sialorrhea

**AND**

3. The member is 18 years of age and older

**Esophageal achalasia in adults**

1. Documented diagnosis of esophageal achalasia

**AND**

2. The member is 18 years of age or older

**AND**

3. Documentation the member is considered a poor candidate for surgical intervention

**Chronic anal fissure**

1. Documented diagnosis of chronic anal fissure(s)

**AND**

2. Documented inadequate response to or intolerance of conservative or pharmacologic treatments, or the Provider has determined that conservative or pharmacologic treatments are clinically inappropriate (e.g., topical calcium channel blockers, nitrates)

**Severe axillary hyperhidrosis**

1. Documented diagnosis of severe axillary hyperhidrosis

**AND**

2. The member is 18 years of age and older

**AND**

3. Documented inadequate response to or intolerance of **one (1)** topical agent or the Provider has determined that topical agents would be clinically inappropriate (e.g. Drysol (20% aluminum chloride hexahydrate)

**Overactive Bladder with Symptoms of Urge Urinary Incontinence**

1. Documented diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency

**AND**

2. The member is 5 years of age or older

**AND**

3. Documented inadequate response to or intolerance to **one (1)** anticholinergic medication or the provider has determined that an anticholinergic medication is clinically inappropriate (e.g., oxybutynin, tolterodine, darifenacin)

**Urinary incontinence due to detrusor overactivity associated with a neurologic condition**

1. Documented diagnosis of urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury, multiple sclerosis]

**AND**

2. The member is 18 years of age or older

**AND**

3. Documented inadequate response to or intolerance to **one (1)** anticholinergic medication, or the provider has determined that an anticholinergic medication is clinically inappropriate (e.g., oxybutynin, tolterodine, darifenacin)

**Prophylaxis of headaches in adult patients with chronic migraine**

1. Documented diagnosis of chronic migraine headaches, defined as headaches occurring on at least 15 or more days per month and lasting at least 4 hours a day or longer

**AND**

2. Documentation the requested medication is being prescribed as preventive therapy

**AND**

3. The member is 18 years of age or older

**Blepharospasm**

1. Documented diagnosis of blepharospasm

**AND**

2. The member is 12 years of age and older

**Hemifacial spasm**

1. Documented diagnosis of hemifacial spasm

**AND**

The member is 18 years of age or older

## Limitations

- The plan does not provide coverage for cosmetic procedures or localization procedures that involve the use of botulinum toxin injection.
- Refer to the Medicare Part B Step Therapy Medical Necessity Guideline for additional requirements.

## Codes

The following code(s) require prior authorization:

**Table 1: HCPCS Codes**

| HCPCS Codes | Description |
|---|---|
| J0587 | Injection, rimabotulinumtoxinB, 100 units |

## References


1. Myobloc [package insert]. Rockville, MD: Supernus Pharmaceuticals, Inc.; March 2021. https://www.myobloc.com/files/MYOBLOC_PI.pdf.
2. Centers of Medicare and Medicaid Services (CMS). LCD - Botulinum Toxins (L33646). Cms.Gov, 2021, https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33646. Accessed Dec 2023
3. Centers of Medicare and Medicaid Services (CMS). LCD - Botulinum Toxins (L38809). Cms.Gov, 2021, https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=38809&ver=6. Accessed Dec 2023.


## Approval And Revision History

September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee (P&T)

Subsequent endorsement date(s) and changes made:

- September 21, 2022: Reviewed by the Medical Policy Approval Committee (MPAC)
- September 12, 2023: Removed the following Limitations The health plan may authorize coverage of Myobloc up to 12 months if coverage criteria are met, All other indications are considered experimental/investigational and not medically necessary, The health plan does not cover Myobloc for hyperhidrosis, and The health plan does not cover Myobloc for prophylaxis of episodic migraine. Updated the Limitations regarding cosmetic and localization procedures to “The plan does not provide coverage for cosmetic procedures and localization procedures that involve the use of botulinum toxin injection.” Minor wording updates to clarify coverage.” Added the following Limitation: Refer to the Medicare Part B Step Therapy Medical Necessity Guideline for additional requirements. (effective 1/1/2024).
- December 12, 2023: To be in line with L38809 added coverage criteria for esophageal achalasia, chronic anal fissure, urinary incontinence due to detrusor overactivity associated with a neurologic condition, severe axillary hyperhidrosis, overactive bladder with symptoms of urge urinary incontinence, prophylaxis of headaches in adult patients with chronic migraine, hemifacial spasm, and blepharospasm. Administrative Update in support of calendar year 2024 Medicare Advantage and PDP Final Rule (eff 1/1/24)

## Background, Product and Disclaimer Information

Point32Health prior authorization criteria to be applied to Medicare Advantage plan members is based on guidance from Medicare laws, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When no guidance is provided, Point32Health uses clinical practice guidance published by relevant medical societies, relevant medical literature, Food and Drug Administration (FDA)-approved package labeling, and drug compendia to develop prior authorization criteria to apply to Medicare Advantage plan members. Medications that require prior authorization generally meet one or more of the following criteria: Drug product has the potential to be used for cosmetic purposes; drug product is not considered as first-line treatment by medically accepted practice guidelines, evidence to support the safety and efficacy of a drug product is poor, or drug product has the potential to be used for indications outside of the indications approved by the FDA. Prior authorization and use of the coverage criteria within this Medical Necessity Guideline will ensure drug therapy is medically necessary, clinically appropriate, and aligns with evidence-based guidelines. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests revisions.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.