Clinical Policy: OnabotulinumtoxinA (Botox)
Reference Number: CP.PHAR.232
Effective Date: 07.01.16
Last Review Date: 05.19
Line of Business: Commercial, HIM, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
OnabotulinumtoxinA (Botox®) is an acetylcholine release inhibitor and a neuromuscular blocking agent.

FDA Approved Indication(s)
Botox is indicated for:

- Treatment of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication
- Treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication
- Prophylaxis of headaches in adult patients with chronic migraine (≥15 days per month with headache lasting 4 hours a day or longer)
- Treatment of upper and lower limb spasticity in adult patients
- Treatment of upper limb spasticity in pediatric patients 2 to 17 years of age
- Treatment of lower limb spasticity in pediatric patients 2 to 17 years of age, excluding spasticity caused by cerebral palsy
- Treatment of cervical dystonia (CD) in adult patients, to reduce the severity of abnormal head position and neck pain
- Treatment of severe axillary hyperhidrosis that is inadequately managed by topical agents in adult patients
- Treatment of blepharospasm associated with dystonia in patients ≥12 years of age
- Treatment of strabismus in patients ≥12 years of age

Limitation(s) of use: Safety and effectiveness of Botox have not been established for:
- Prophylaxis of episodic migraine (14 headache days or fewer per month)
- Treatment of hyperhidrosis in body areas other than axillary

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 Botox is medically necessary when one of the following criteria is met:

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   Error! Bookmark not defined.

I. Initial Approval Criteria
   A. Cervical Dystonia (must meet all):
      1. Diagnosis of CD (see Appendix D):
      2. Prescribed by or in consultation with a neurologist, orthopedist, physiatrist, or physical medicine and rehabilitation specialist;
      3. Age ≥ 16 years;
      4. Experiencing involuntary contractions of the neck and shoulder muscles (e.g., splenius capitis, 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 Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
7. Dose does not exceed 400 units per treatment session.

Approval duration:
Medicaid/HIM – 12 weeks (single treatment session)
Commercial – 6 months or to member’s renewal date, whichever is longer

B. Blepharospasm (a focal dystonia) or Strabismus (must meet all):
1. Diagnosis (a or b):
   a. Blepharospasm (i.e., abnormal contraction of eyelid muscles);
   b. Strabismus (i.e., misalignment of the eyes);
2. Prescribed by or in consultation with a neurologist or ophthalmologist;
3. Age ≥ 12 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 Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed (a or b):
   a. Blepharospasm: 5 units per site per treatment session (maximum of 200 units total in a 30-day period);
   b. Strabismus: 25 units per muscle per treatment session.

Approval duration:
Medicaid/HIM – 12 weeks (single treatment session)
Commercial – 6 months or to member’s renewal date, whichever is longer

C. Other Dystonias (off-label) (must meet all):
1. Diagnosis of dystonia (see definitions and types in Appendices D and E);
2. Prescribed by or in consultation with a neurologist, orthopedist, physiatrist, or physical medicine and rehabilitation specialist;
3. Failure of a trial of carbidopa/levodopa or trihexyphenidyl unless contraindicated or clinically significant adverse effects are experienced;
4. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
5. Dose does not exceed 400 units per single treatment with the following exceptions:
   a. Oromandibular dystonia: 25 units per muscle per treatment session;
   b. Laryngeal dystonia (spasmodic dysphonia): 3 units per treatment session.

Approval duration:
Medicaid/HIM – 12 weeks (single treatment session)
Commercial – 6 months or to member’s renewal date, whichever is longer

D. Upper and Lower Limb Spasticity (must meet all):
1. Diagnosis of upper or lower limb spasticity;
2. Prescribed by or in consultation with a neurologist, orthopedist, physiatrist, or physical medicine and rehabilitation specialist;
3. Age ≥ 2 years;
4. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
5. Request meets one of the following (a or b):
   a. If age ≥ 18 years, dose does not exceed 400 units per treatment session;
   b. If age is 2 years to 17 years, dose does not exceed (i or ii):
      i. 6 units/kg or 200 units (whichever is lower) per treatment session for upper limb spasticity;
      ii. 8 units/kg or 300 units (whichever is lower) per treatment session for lower limb spasticity.

Approval duration:
Medicaid/HIM – 12 weeks (single treatment session)
Commercial – 6 months or to member’s renewal date, whichever is longer

E. Spasticity Associated with Cerebral Palsy (off-label) (must meet all):
1. Diagnosis of spasticity associated with cerebral palsy (CP);
2. Prescribed by or in consultation with a neurologist, physiatrist, or physical medicine and rehabilitation specialist;
3. Age ≥ 2 years;
4. Focal increased muscle tone interferes with function or is likely to lead to joint contracture with growth;
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed 400 units per treatment session.

Approval duration:
Medicaid/HIM – 12 weeks (single treatment session)
Commercial – 6 months or to member’s renewal date, whichever is longer

F. Chronic Migraine (must meet all):
1. Diagnosis of chronic migraine (≥ 15 days per month for at least 3 months with headache lasting 4 hours a day or longer);
2. Prescribed by or in consultation with a neurologist or pain specialist;
3. Age ≥ 18 years;
4. Failure of an 8-week trial of at least 2 oral migraine preventative therapies (e.g., antiepileptic drugs: divalproex sodium, sodium valproate, topiramate; beta-blockers: metoprolol, propranolol, timolol; antidepressants: amitriptyline, venlafaxine), unless contraindicated or clinically significant adverse effects are experienced;
5. Botox is not prescribed concurrently with injectable CGRP inhibitors (e.g., Aimovig™, Ajovy™, Emgality™);
6. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
7. Dose does not exceed 200 units per treatment session.

Approval duration:
Medicaid/HIM – 24 weeks (two 12-week treatment sessions)
Commercial – 6 months or to member’s renewal date, whichever is longer

G. Primary Axillary Hyperhidrosis* (must meet all):
*The treatment of hyperhidrosis is a benefit exclusion for HIM
1. Diagnosis of severe primary axillary hyperhidrosis (e.g., resulting in medical complications such as skin maceration and infection or significant disruption of professional/social life);
2. Prescribed by or in consultation with a neurologist or dermatologist;
3. Age ≥ 18 years;
4. Failure of a 6-month trial of topical aluminum chloride, unless contraindicated or clinically significant adverse effects are experienced;
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed 50 units per axilla per treatment session.

Approval duration:
Medicaid – 12 weeks (single treatment session)
HIM – Benefit Exclusion (Not Approvable)
Commercial – 6 months or to member’s renewal date, whichever is longer

H. Overactive Bladder and Urinary Incontinence (must meet all):
1. Diagnosis (a or b):
   a. Overactive bladder;
   b. Urinary incontinence associated with a neurologic condition (e.g., spinal cord injury, MS);
2. Prescribed by or in consultation with a neurologist or urologist;
3. Age ≥ 18 years;
4. Failure of a trial of at least two anticholinergic agents and one oral beta-3 agonist medication (e.g., oxybutynin chloride, tolterodine tartrate, mirabegron), each used for at least 30 days, unless contraindicated or clinically significant adverse effects are experienced;
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed (a or b):
   a. Overactive bladder: 100 units per treatment session;
   b. Urinary incontinence: 200 units per treatment session.

Approval duration:
Medicaid/HIM – 12 weeks (single treatment session)
Commercial – 6 months or to member’s renewal date, whichever is longer

I. Esophageal Achalasia (off-label) (must meet all):
1. Diagnosis of esophageal achalasia (i.e., failure of relaxation of the lower esophageal sphincter accompanied by loss of peristalsis in the distal esophagus);
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Member is not a good candidate for pneumatic dilation or myotomy (e.g., high surgical risk due to age, comorbidities);
5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
6. Dose does not exceed 100 units.

Approval duration:
- Medicaid/HIM – 12 weeks (single treatment session)
- Commercial – 6 months or to member’s renewal date, whichever is longer

J. Hirschsprung’s Disease and Internal Anal Sphincter Achalasia (off-label) (must meet all):
   1. Diagnosis (a or b):
      a. Hirschsprung’s disease (HD) (i.e., heritable motor disorder of the gut with failure of the colon to relax causing functional obstruction; usually diagnosed infancy or childhood) (i or ii):
         i. Botox will be used for constipation due to increased internal anal sphincter tone after surgery;
         ii. Member is diagnosed with ultra-short segment HD;
      b. Internal anal sphincter (IAS) achalasia (i.e., lack of rectoanal inhibitory reflex on anal manometry; presents in infancy – may mimic HD);
   2. Prescribed by or in consultation with a gastroenterologist;
   3. Failure of a trial of stool softeners and laxatives;
   4. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
   5. Dose does not exceed 100 units.

Approval duration:
- Medicaid/HIM – 12 weeks (single treatment session)
- Commercial – 6 months or to member’s renewal date, whichever is longer

K. Chronic Anal Fissure (off-label) (must meet all):
   1. Diagnosis of chronic anal fissures;
   2. Prescribed by or in consultation with a gastroenterologist or colorectal surgeon;
   3. Age ≥ 18 years;
   4. Failure of a trial of nitroglycerin ointment, unless contraindicated or clinically significant side effects are experienced;
   5. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
   6. Dose does not exceed 100 units.

Approval duration:
- Medicaid/HIM – 12 weeks (single treatment session)
- Commercial – 6 months or to member’s renewal date, whichever is longer
L. 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. Chronic Migraine (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. If member has received 2 or more Botox treatment sessions, has experienced and maintained a 30% reduction in monthly migraine headache frequency from baseline;
      4. It has been at least 12 weeks since the last injection of Botox;
      5. Botox is not prescribed concurrently with injectable CGRP inhibitors (e.g., Aimovig, Ajovy, Emgality);
      6. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
      7. If request is for a dose increase, new dose does not exceed 200 units per treatment session.

   Approval duration:
   Medicaid/HIM – 24 weeks (two 12-week treatment sessions)
   Commercial – 6 months or to member’s renewal date, whichever is longer

   B. Esophageal Achalasia (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 24 weeks since the last injection of Botox;
      4. Provider submits treatment plan detailing the quantity (in units) of Botox 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 100 units per treatment session.

   Approval duration:
   Medicaid/HIM – 24 weeks (single treatment session)
   Commercial – 6 months or to member’s renewal date, whichever is longer

   C. All Other Indications in Section I* (must meet all):
      *The treatment of hyperhidrosis is a benefit exclusion for HIM
      1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
      2. Member is responding positively to therapy;
      3. It has been at least 12 weeks since the last injection of Botox;
4. Provider submits treatment plan detailing the quantity (in units) of Botox to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;

5. Meets (a or b):
   a. If request is for upper and/or lower limb spasticity and member is between 2 and 17 years of age, Botox administration has not exceeded 10 units/kg body weight or 340 units over the last 3 months;
   b. For all other indications in this section, Botox administration has not exceeded 400 units over the last 3 months;

6. If request is for a dose increase, new dose does not exceed any of the following (a-i):
   a. CD, CP: 400 units per treatment session;
   b. Upper/lower limb spasticity (i, ii, or iii):
      i. Age ≥ 18 years: 400 units per treatment session;
      ii. Age 2 years to 17 years: 6 units/kg or 200 units (whichever is lower) per treatment session for upper limb spasticity;
      iii. Age 2 years to 17 years: 8 units/kg or 300 units (whichever is lower) per treatment session for lower limb spasticity;
   c. Blepharospasm: 5 units per site per treatment session (maximum of 200 units total in a 30-day period);
   d. Strabismus: 25 units per muscle per treatment session;
   e. Oromandibular dystonia: 25 units per muscle per treatment session;
   f. Laryngeal dystonia (spasmodic dysphonia): 3 units per treatment session;
   g. Primary axillary hyperhidrosis: 50 units per axilla per treatment session;
   h. Overactive bladder, HD, IAS achalasia, chronic anal fissures: 100 units per treatment session;
   i. Urinary incontinence: 200 units per treatment session.

Approval duration:
Medicaid/HIM – 12 weeks (single treatment session)
Commercial – 6 months or to member’s renewal date, whichever is longer

D. Other diagnoses/indications (1 or 2):
   1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
      Approval duration: 12 weeks (single treatment session); 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
- CP: cerebral palsy
- FDA: Food and Drugs Administration
- HD: Hirschsprung’s disease
- IAS: internal anal sphincter
- MS: multiple sclerosis
- SCI: spinal cord injury
- TMD: temporomandibular disorders
- TMJ: temporomandibular joint

**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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>carbidopa/levodopa (Sinemet®, Duopa®, Rytary®)</td>
<td><strong>Other Dystonias</strong> <em>(see appendices C and D)</em>&lt;br&gt;25 mg/100 mg PO QD, and increase by 1 tablet every 3 to 5 days.</td>
<td>1,200 mg/day of levodopa</td>
</tr>
<tr>
<td>trihexyphenidyl</td>
<td><strong>Other Dystonias</strong> <em>(see appendices C and D)</em>&lt;br&gt;30 mg PO QD</td>
<td>30 mg/day</td>
</tr>
<tr>
<td>lactulose</td>
<td><strong>Hirschsprung’s Disease, Internal Anal Sphincter Achalasia, Chronic anal fissure</strong>&lt;br&gt;15-30 ml PO QD</td>
<td>60 mL/day</td>
</tr>
<tr>
<td>Senokot® (sennosides)</td>
<td><strong>Hirschsprung’s Disease, Internal Anal Sphincter Achalasia, Chronic anal fissure</strong>&lt;br&gt;Two 8.6 mg tabs PO QD-BID</td>
<td>34.4 mg/day</td>
</tr>
<tr>
<td>Metamucil® (psyllium)</td>
<td><strong>Chronic anal fissure</strong>&lt;br&gt;One rounded tsp in 8 oz liquid PO up to TID</td>
<td>3 doses/day</td>
</tr>
<tr>
<td>Dulcolax® (bisacodyl)</td>
<td><strong>Hirschsprung’s Disease, Internal Anal Sphincter Achalasia, Chronic anal fissure</strong>&lt;br&gt;5 to 15 mg PO or 10 mg PR QD</td>
<td>30 mg/day</td>
</tr>
<tr>
<td>FiberCon® (Calcium polycarbophil)</td>
<td><strong>Chronic anal fissure</strong>&lt;br&gt;Two 625 mg tabs PO QD-QID</td>
<td>5000 mg/day</td>
</tr>
<tr>
<td>Citrucel® (Methylcellulose)</td>
<td><strong>Chronic anal fissure</strong>&lt;br&gt;Caplet: 2 caplets up to 6 times daily&lt;br&gt;Powder: 2 grams in 8 oz of cold water by mouth up to 3 times daily</td>
<td>12 caplets/day or 6 grams/day</td>
</tr>
<tr>
<td>Drug Name</td>
<td>Dosing Regimen</td>
<td>Dose Limit/Maximum Dose</td>
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<tr>
<td>MiraLax® (Polyethylene glycol 3350)</td>
<td><strong>Hirschsprung’s Disease, Internal Anal Sphincter Achalasia, Chronic anal fissure</strong>&lt;br&gt;17 grams of polyethylene glycol 3350 in 4-8 oz water by mouth once daily</td>
<td>17 grams/day</td>
</tr>
<tr>
<td>Colace® (Docusate sodium)</td>
<td><strong>Hirschsprung’s Disease, Internal Anal Sphincter Achalasia, Chronic anal fissure</strong>&lt;br&gt;50-200 mg PO QD-QID</td>
<td>200 mg/day</td>
</tr>
<tr>
<td>nitroglycerin 0.2% ointment (Rectiv®)</td>
<td><strong>Chronic anal fissure</strong>&lt;br&gt;15 to 30 mg (2.5 to 5 cm as squeezed from the tube, about 1 to 2 inches), applied topically to the skin every 8 hours while awake and at bedtime; frequency of application may be increased to every 6 hours if needed. Alternatively, a regimen providing a 12-hour nitrate-free interval may be used; apply dosage once each morning, then reapply 6 hours later</td>
<td>75 mg (12.5 cm as squeezed from the tube)/day</td>
</tr>
<tr>
<td>oxybutynin (Ditropan®/XL, Gelnique®)</td>
<td><strong>Overactive Bladder</strong>&lt;br&gt;Immediate-release tablets: 5 mg orally two to three times daily&lt;br&gt;Extended-release tablets: 5-10 mg orally once daily&lt;br&gt;Topical gel: Apply contents of one sachet topically once daily</td>
<td>Immediate-release: 20 mg/day&lt;br&gt;Extended-release: 30 mg/day&lt;br&gt;Gel: one sachet/day</td>
</tr>
<tr>
<td>tolterodine tartrate (Detrol®/LA)</td>
<td><strong>Overactive Bladder</strong>&lt;br&gt;Immediate-release tablets: 2 mg orally twice daily&lt;br&gt;Extended-release tablets: 4 mg orally once daily</td>
<td>4 mg/day</td>
</tr>
<tr>
<td>Myrbetriq® (mirabegron)</td>
<td><strong>Overactive Bladder</strong>&lt;br&gt;25 mg orally once daily</td>
<td>50 mg/day</td>
</tr>
<tr>
<td>Anticonvulsants such as: divalproex (Depakote®), topiramate (Topamax®)</td>
<td><strong>Chronic Migraines</strong>&lt;br&gt;<em>Refer to prescribing information</em></td>
<td><em>Refer to prescribing information</em></td>
</tr>
<tr>
<td>Beta blockers such as:</td>
<td><strong>Chronic Migraines</strong>&lt;br&gt;<em>Refer to prescribing information</em></td>
<td><em>Refer to prescribing information</em></td>
</tr>
<tr>
<td>Drug Name</td>
<td>Dosing Regimen</td>
<td>Dose Limit/Maximum Dose</td>
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<tr>
<td>propranolol (Inderal®), metoprolol (Lopressor®), timolol</td>
<td><strong>Chronic Migraines</strong></td>
<td>Refer to prescribing information</td>
</tr>
<tr>
<td>Antidepressants/tricyclic antidepressants such as: amitriptyline (Elavil®), venlafaxine (Effexor®)</td>
<td><strong>Chronic Migraines</strong></td>
<td>Refer to prescribing information</td>
</tr>
<tr>
<td>Non-steroidal anti-inflammatory drugs (NSAIDs) such as: fenoprofen (Nalfon®), ibuprofen (Motrin®), ketoprofen (Orudis®), naproxen (Naprosyn®)</td>
<td><strong>Chronic Migraines</strong></td>
<td>Refer to prescribing information</td>
</tr>
<tr>
<td>Drysol® (aluminum chloride)</td>
<td><strong>Primary Axillary Hyperhidrosis</strong></td>
<td>One application/day</td>
</tr>
</tbody>
</table>

*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 and Boxed Warnings**
- **Contraindication(s):**
  - Hypersensitivity to any botulinum toxin preparation or to any of the components in the formulation
  - Infection at the proposed injection site
  - Intradetrusor injections: urinary tract infection or urinary retention
- **Boxed warning(s):** distant spread of toxin effect

**Appendix D: 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.
### Appendix E: Descriptions and Examples of Dystonia Syndromes*

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Description and Examples</th>
</tr>
</thead>
</table>
| Isolated dystonias | Early-onset generalized isolated dystonia | Dystonia with focal-onset in childhood often progresses to generalized involvement. Cases may be sporadic, familial, genetically defined or without known cause.  
- Early-onset generalized dystonia (DYT-TOR1A)  
- Adolescent-onset dystonia of mixed type (DYT-THAP1) |
| Adult-onset focal or segmental isolated dystonia | Usually begins after age 30 years. Most are sporadic without identifiable cause. Rarely progress to generalized dystonia but can extend to contiguous body regions.  
- Adult-onset segmental dystonia (DYT-GNAL)  
- Cervical dystonia  
- Blepharospasm  
- Writer’s cramp  
- Oromandibular dystonia  
- Laryngeal dystonia (spasmodic dysphonia)  
- Limb dystonia |
| Combined dystonias | Dystonia-parkinsonism | Disorders that combine dystonia and parkinsonian features. May be accompanied by pyramidal tract involvement or nonmotor features including cognitive decline. Many are inherited.  
- Dopa-responsive dystonia (DYT-GCH1, DYT-TH, and DYT-SPR)  
- Wilson disease  
- Early-onset parkinsonism (PARK-PARKIN)  
- Conditions associated with neurodegeneration with brain iron accumulation |
| Myoclonus-dystonia | Disorders in which there is a combination of dystonia and myoclonus. Dystonia may be mild and myoclonus generally predominates.  
- Myoclonus-dystonia (DYT-SGCE) |
| Paroxysmal dyskinesia with dystonia | Disorders characterized by episodes of spontaneous or induced dyskinesia with dystonia.  
- Paroxysmal nonkinesigenic dyskinesia (DYT-MR1) |

*Table adapted with permission from: Comella C. Classification and evaluation of dystonia. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. Available at www.uptodate.com. Accessed on June 22, 2017.

### Appendix F: General Information
- The potency units of botulinum toxin products are specific to the preparation and assay method utilized. They are not interchangeable with other preparations of botulinum toxin products and, therefore, units of biological activity of one product cannot be compared to nor converted into units of any other botulinum toxin products assessed with any other specific assay method.
- Safety and effectiveness have not been established for the prophylaxis of episodic migraine (14 headache days or fewer per month) and is a Class III recommendation in Micromedex.
• Indication specific dosage and administration recommendations should be followed for Botox. When initiating treatment, the lowest recommended dose should be used. In treating adult patients for one or more indications, the maximum cumulative dose should not exceed 400 Units, in a 3 month interval.

• For detrusor overactivity associated with a neurologic condition there was no additional benefit of Botox 300 Units over 200 Units.

• Safety and effectiveness have not been uniformly established for the treatment of temporomandibular disorders (TMD). Use of botulinumtoxin for this indication is a Class IIb recommendation in Micromedex based on a single study from 1999. A review of two clinical studies (from 2002 and 2011) (15 and 21 patients) found no significant differences in pain reduction between botulinumtoxin and placebo. Other small studies (from 2005 - Italy and 2008 - Turkey) have been performed and showed improvement in objective measures of pain (20 patients and 26 patients). The most common total dose of BTX-A used in the studies was 25u for each temporalis muscle and 50u for each masseter muscle. The studies did not repeat the dosing, but measured efficacy at 16 weeks post dose. The 2003 Guidelines for diagnosis and management of disorders involving the temporomandibular joint and related musculoskeletal structures mention Botox as a possible treatment option for temporomandibular joint (TMJ) based on its mechanism of action and the pathophysiology of TMD.
  o TMD “gold standard” treatment continues to be: 1) TMJ intraoral orthotic; 2) Muscle relaxants by mouth; and 3) Home muscle relaxation exercises/techniques.

• Limb spasticity may be caused by heredity spastic paraplegia, multiple sclerosis or other demyelinating diseases of the central nervous system, spastic hemiplegia, infantile cerebral palsy, and stroke.

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Condition</th>
<th>Average Duration of Effect</th>
<th>Average Dose</th>
<th>Maximum dose per treatment session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blepharospasm</td>
<td>12.5 weeks</td>
<td>5 units per site</td>
<td>200 units total in a 30-day period</td>
</tr>
<tr>
<td>Strabismus</td>
<td>6-8 weeks to 6-12 months</td>
<td>2.5 to 5 units per muscle (max 25 units)</td>
<td>25 units</td>
</tr>
<tr>
<td>Cervical dystonia</td>
<td>4 weeks to 3 months</td>
<td>200 to 300 units divided among affected muscles</td>
<td>400 units</td>
</tr>
<tr>
<td>Oromandibular dystonia*</td>
<td>10 to 14 weeks</td>
<td>25 units per muscle per treatment</td>
<td>100 units</td>
</tr>
<tr>
<td>Spasmodic dysphonia*</td>
<td>3-6 months</td>
<td>0.031 to 10 units per vocal cord. 5 to 30 units in abductor muscle</td>
<td>400 units</td>
</tr>
<tr>
<td>Overactive bladder</td>
<td>12 weeks</td>
<td>Total dose 100 Units, as 0.5 mL (5 Units) injections across 20 sites into the detrusor. Repeat doses should be 12 weeks apart</td>
<td>400 units</td>
</tr>
</tbody>
</table>
## Botox (onabotulinumtoxin A) Dose Chart

<table>
<thead>
<tr>
<th>Condition</th>
<th>Average Duration of Effect</th>
<th>Average Dose</th>
<th>Maximum dose per treatment session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spastic muscle contracture of pediatric cerebral palsy*</td>
<td>1-6 months</td>
<td>3 to 6 units/kg (maximum 12 units/kg). total dose 82 to 220 units divided among affected muscles</td>
<td>100 units</td>
</tr>
<tr>
<td>Childhood myoclonus following failure of Baclofen, benzodiazepines, and antiseizure medications*</td>
<td>4-8 months</td>
<td>8 to 80 units/kg</td>
<td>400 units</td>
</tr>
<tr>
<td>Chronic anal fissure*</td>
<td>Single Injection</td>
<td>20 units both sides</td>
<td>80 units/kg</td>
</tr>
<tr>
<td>Internal anal sphincter achalasia*</td>
<td>Single treatment. Patient may require repeat treatment. Adults or children</td>
<td>15 units to 25 units in each quadrant or up to 50 units on either side of IAS</td>
<td>100 units</td>
</tr>
<tr>
<td>Axillary hyperhidrosis</td>
<td>4-12 months</td>
<td>50 units per axilla</td>
<td>100 units</td>
</tr>
<tr>
<td>Migraines</td>
<td>3-4 months</td>
<td>155 to 195 total units given in 5 to 40 units/site</td>
<td>200 units</td>
</tr>
<tr>
<td>Neurogenic bladder</td>
<td>8-12 months</td>
<td>200 units given in multiple sites</td>
<td>200 units</td>
</tr>
<tr>
<td>Adult upper limb spasticity</td>
<td>12 weeks</td>
<td>12.5 units to 50 units in one site</td>
<td>400 units</td>
</tr>
<tr>
<td>Adult lower limb spasticity</td>
<td>12 weeks</td>
<td>300 units to 400 units divided among 5 muscles</td>
<td>400 units</td>
</tr>
<tr>
<td>Pediatric upper limb spasticity</td>
<td>12 weeks</td>
<td>3 units/kg to 6 units/kg divided among the affected muscles</td>
<td>6 units/kg or 200 units, whichever is lower</td>
</tr>
<tr>
<td>Pediatric lower limb spasticity</td>
<td>12 weeks</td>
<td>4 units/kg to 8 units/kg divided among the affected muscles</td>
<td>8 units/kg or 300 units, whichever is lower</td>
</tr>
</tbody>
</table>

*Off-label uses*

### VI. Product Availability
Vial of powder for solution for injection: 100 units, 200 units

### VII. References

Dystonias, Spasticity, Chronic Migraine


Primary Axillary Hyperhidrosis, Overactive Bladder, Urinary Incontinence


**Esophageal Achalasia**


**Hirschsprung’s Disease, Internal Anal Sphincter Achalasia**


**Chronic Anal Fissures**


**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.

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J0585</td>
<td>Injection, onabotulinumtoxinA, 1 unit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy split from CP.PHAR.09.</td>
<td></td>
<td>05.16</td>
</tr>
<tr>
<td>Added new FDA indication of lower limb spasticity per FDA labeling.</td>
<td></td>
<td>07.16</td>
</tr>
<tr>
<td>Added compendial indication of laryngeal spasm/spasmodic dysphonia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Overactive bladder: modified requirement for trial/failure of previous therapy to include oral beta-3 agonist medications per AUA guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Migraine: modified continuation criteria to require 30% reduction in headache frequency after 2 injections rather than just 1 per literature review and NICE guidelines.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Added general max dosing limit for cerebral palsy and spastic conditions and indication-specific max dosing limit for cervical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reviews, Revisions, and Approvals</td>
<td>Date</td>
<td>P&amp;T Approval Date</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------</td>
<td>----------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>
| dystonia, strabismus, primary axillary hyperhidrosis, upper limb spasticity, overactive bladder, urinary incontinence, and chronic migraine per PI.  
-Added indication-specific max dosing limit for chronic anal fissures, esophageal achalasia, laryngeal spasm/spasmodic dysphonia, Hirschsprung’s disease, and dystonias per literature review.  
-Added prescriber requirement for overactive bladder, urinary incontinence, chronic migraines, upper limb spasticity, primary axillary hyperhidrosis, chronic anal fissures, cerebral palsy, esophageal achalasia, dystonias, Hirschsprung’s disease, and spastic conditions.  
-Added age restriction for upper limb spasticity and primary axillary hyperhidrosis per PI, and for chronic anal fissures, esophageal achalasia, and Hirschsprung’s disease per literature review.  
-Added route of administration for each labeled indication per PI.  
-Removed reauthorization criteria requiring attestation of significant improvement in symptoms and/or health-related quality of life. Added positive response to therapy to continuation criteria.  
-Chronic migraine initial approval duration lengthened from 12 to 24 weeks (from one to two treatment sessions) to allow assessment of response as outlined in continuation criteria.  
The off-label criteria set entitled “Spastic Conditions” is deleted due to its broad scope; off-label requests not covered elsewhere in the policy are referred to the CP.PHAR.57.Global Biopharm policy so that they may be reviewed individually. Requirement that provider submits detailed treatment plan added to curtail abuse.  
Indications reorganized. Definition of CD is edited per AAN guidelines. Laryngeal dystonia is merged with off-label dystonias which in turn are entitled “Other Dystonias”. Clarified “blepharospasm” as a focal dystonia. Deleted causes and classifications of blepharospasm; blepharospasm and strabismus definitions are added. Dystonia information is added at Appendices B and C. Added esophageal achalasia definition. IAS achalasia is given its own line item. HD and IAS achalasia definitions added.  
Background FDA indication section and references categorized. “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.  
2Q 2018 annual review: combined Medicaid and Commercial lines of business; added HIM line of business; expanded maximum dose for chronic migraine treatment to 200 units per treatment per 2012 NICE guidelines; Hirschsprung’s Disease and Internal Anal Sphincter Achalasia: removed requirement for dietary and fluid control; added | 11.16    |                  |
<p>|                                                                                                  | 02.17    |                  |
|                                                                                                  | 06.17    | 07.17            |
| 04.24.18 05.18                                                                                   |</p>
<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>physical medicine and rehabilitation specialist for cervical dystonia, other dystonia, upper and lower limb spasticity, and spasticity associated with CP; added pain specialist for migraine; Medicaid: lowered age limit for CD to 16 from 18 years; added physiatrist to accepted specialist for spasticity associated with CP; Commercial: approval durations changed from length of benefit to 6 months or to member’s renewal date, whichever is longer for initial and continued approval; references reviewed and updated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2Q 2019 annual review: added requirement that Botox is not prescribed concurrently with injectable CGRP inhibitors; removed coverage for hyperhidrosis for HIM due to benefit exclusion; references reviewed and updated.</td>
<td>01.15.19</td>
<td>05.19</td>
</tr>
<tr>
<td>RT4: criteria added for newly FDA approved indication for pediatric extension of upper limb spasticity.</td>
<td>07.23.19</td>
<td></td>
</tr>
<tr>
<td>RT4: criteria added for newly FDA approved indication for pediatric extension of lower limb spasticity; removed 2% specific strength requirement for nitroglycerin ointment due to availability reasons; added disclaimer regarding hyperhidrosis as a benefit exclusion for HIM on continued therapy section.</td>
<td>11.06.19</td>
<td></td>
</tr>
</tbody>
</table>

**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.

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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.

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 formulary exception policy.

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