

Clinical Policy: RimabotulinumtoxinB (Myobloc)

Reference Number: CP.PHAR.233

Effective Date: 07.01.16

Last Review Date: 05.18

Line of Business: Commercial, Medicaid

[Coding Implications](#)

[Revision Log](#)

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

Description

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

FDA Approved Indication(s)

Myobloc is indicated for the treatment of adults with cervical dystonia (CD) to reduce the severity of abnormal head position and neck pain associated with CD.

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 Myobloc is **medically necessary** when one of the following criteria are met:

I. Initial Approval Criteria

A. Cervical Dystonia (must meet all):

1. Diagnosis of CD (*see Appendix C*);
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 capitis, sternocleidomastoid, levator scapulae, scalene, trapezius, semispinalis capitis) resulting in abnormal postures or movements of the neck, shoulders or head;
5. Contractions are causing pain and functional impairment;
6. Provider submits treatment plan detailing the quantity (in units) of Myobloc to be injected in each muscle site, anticipated frequency of injection, and total dose per visit;
7. Dose does not exceed 10,000 units per treatment session.

Approval duration:

Medicaid – 12 weeks (single treatment session)

Commercial – 6 months

B. Other diagnoses/indications:

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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 and CP.PMN.53 for Medicaid.

II. Continued Approval

A. Cervical Dystonia (must meet all):

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 Myobloc;
4. Provider submits treatment plan detailing the quantity (in units) of Myobloc 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 10,000 units per treatment session.

Approval duration:

Medicaid – 12 weeks (single treatment session)

Commercial – 12 months

B. 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 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 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: Definition and Classification of Dystonia*³

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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
Cervical dystonia	<p>The initial dose of Myobloc for patients with a history of tolerating botulinum toxin injections is 2,500 to 5,000 U divided among affected muscles. Give patients without a history of tolerating botulinum toxin injections a lower initial dose.</p> <p>Optimize subsequent dosing according to the patient's individual response. The duration of effect has been observed in studies to be between 12 and 16 weeks at doses of 5000 U or 10,000 U.</p>	10,000 units/12 weeks

VI. Product Availability

Vials: 2,500 units, 5,000 units, 10,000 units

VII. References

1. Myobloc Prescribing Information. South San Francisco, CA: Solstice Neurosciences, Inc.; May 2010. Available at http://www.myobloc.com/hp_about/PI_5-19-10.pdf. Accessed February 16, 2018.
2. 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.
3. 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-

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

HCPCS Codes	Description
J0587	Injection, rimabotulinumtoxinB, 100 units

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy split from CP.PHAR.09. 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
Added definition and requirement of pain and functional impairment to CD. Added examples of muscle groups and an informational footnote to upper limb spasticity. Efficacy statement added under continuation criteria. Safety information removed. 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; combined Medicaid and Commercial lines of business; added HIM; 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
HIM removed as Myobloc does not require prior authorization for this line of business	05.29.18	

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.

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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.

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