Clinical Policy: OnabotulinumtoxinA (Botox)

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Line of Business: Medicaid

Coding Implications
Revision Log

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)

Indication	Adults	Pediatrics	Treatment	Prophylaxis
Overactive bladder	X		X	
Urinary incontinence	X		X	
Migraine	X			X
Upper/lower limb spasticity (includes CP)	X	X	X	
Cervical dystonia (focal dystonia)	X	X	X	
Axillary hyperhidrosis	X		X	
Blepharospasm (focal dystonia)	X	X	X	
Strabismus	X	X	X	
Off-Label Uses				
Laryngeal dystonia*	X		X	
Oromandibular dystonia*	X		X	
Upper extremity dystonia*	X	X	X	
Upper extremity essential tremor*	X		X	
Esophageal achalasia	X		X	
HD and IAS achalasia	X	X	X	
Chronic anal fissure	X		X	

Abbreviations: cerebral palsy (CP); Hirschsprung disease (HD), internal anal sphincter (IAS) achalasia.
**See criteria set entitled Focal Dystonia and Essential Tremor*

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
  - Urinary incontinence due to detrusor over-activity 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
  - Neurogenic detrusor overactivity (NDO) in pediatric patients 5 years of age and older who have an inadequate response to or are intolerant of anticholinergic medication
  - Spasticity in patients 2 years of age and older
  - Cervical dystonia (CD) in adult patients, to reduce the severity of abnormal head position and neck pain

  - Severe axillary hyperhidrosis that is inadequately managed by topical agents in adult patients
  - Blepharospasm associated with dystonia in patients ≥ 12 years of age
  - Strabismus in patients ≥ 12 years of age
- Prophylaxis of headaches in adult patients with chronic migraine (≥ 15 days per month with headache lasting 4 hours a day or longer)

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
  - Treatment of axillary hyperhidrosis in pediatric patients under 18 year of age
- Botox has not been shown to improve upper extremity functional abilities, or range of motion at a joint affected by a fixed contracture.

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.

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It is the policy of health plans affiliated with Centene Corporation® that Botox is **medically necessary** when one of the following criteria is met:

I. Initial Approval Criteria

A. Overactive Bladder and Urinary Incontinence (must meet all)**:**

1. Diagnosis of one of the following (a or b):
   a. OAB, and member's history is positive for urinary urgency, frequency, and nocturia with or without incontinence;
   b. Urinary incontinence, and member's history is positive for an associated neurologic condition (e.g., spinal cord injury, spinal dysraphsim, multiple sclerosis);
2. Prescribed by or in consultation with a neurologist or urologist;
3. Age ≥ 5 years;
4. For adult and pediatric patients, failure of a trial of at least two anticholinergic agents *(see Appendix B)*, each used for at least 30 days, unless clinically significant adverse effects are experienced or all are contraindicated;
5. For adult patients, failure of a 30-day trial of one oral beta-3 agonist medication *(see Appendix B)*, unless clinically significant adverse effects are experienced or all are contraindicated;
6. Member meets both of the following (a and b):
   a. Botox is not prescribed concurrently with other botulinum toxin products;
   b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
7. Treatment plan details number of Units per indication and treatment session;
8. Request meets one of the following (a or b):
   a. OAB: Dose does not exceed 100 Units per treatment session;
   b. Urinary incontinence associated with a neurologic condition:
      i. Weight ≥ 34 kg: dose does not exceed 200 Units per treatment session;
      ii. Weight < 34 kg: dose does not exceed 6 units/kg per treatment session.

Approval duration:
Medicaid – 12 weeks (single treatment session)

B. Chronic Migraine (must meet all)**:**

1. Diagnosis of chronic migraine (i.e., ≥ 15 headache 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 at least 3 of the following oral migraine preventative therapies, each for 8 weeks and from different therapeutic classes, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, or c):
   a. Antiepileptics (e.g., divalproex sodium, sodium valproate, topiramate);
   b. Beta-blockers (e.g., metoprolol, propranolol, timolol);
   c. Antidepressants (e.g., amitriptyline, venlafaxine);
5. If currently receiving calcitonin gene-related peptide (CGRP) therapy for migraine prophylaxis and request is for concurrent use of Botox and CGRP therapy (i.e., not switching from one agent to another), all of the following (a, b, and c):

a. Sufficient evidence is provided from at least two high-quality*, published studies in reputable peer-reviewed journals or evidence-based clinical practice guidelines that provide all of the following (i – iv):
**Case studies or chart reviews are not considered high-quality evidence*
   i. Adequate representation of the member's clinical characteristics, age, and diagnosis;
   ii. Adequate representation of the prescribed drug regimen;
   iii. Clinically meaningful outcomes such as a reduction in monthly migraine or headache days;
   iv. Appropriate experimental design and method to address research questions (*see Appendix E for additional information*);

b. Member has experienced and maintained positive response to CGRP monotherapy as evidenced by a reduction in migraine days per month from baseline following at least 6 months for treatments administered quarterly (every 3 months) (e.g., Ajovy®, Vyepti™) or 3 months for treatments administered at least monthly (e.g., Aimovig®, Ajovy®, Emgality®, Nurtec® ODT, Qulipta™);

c. Despite CGRP monotherapy, member continues to experience chronic migraine (i.e., ≥ 15 headache days per month for at least 3 months with headache lasting 4 hours a day or longer) and/or severe migraine headaches that result in disability and functional impairment;

6. Botox is not prescribed concurrently with other botulinum toxin products;
7. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
8. Treatment plan details number of Units per indication and treatment session;
9. Dose does not exceed 155 Units per treatment session.

Approval duration:
Medicaid – 24 weeks (two 12-week treatment sessions)

C. Upper and Lower Limb Spasticity *(includes cerebral palsy)* (must meet all)**:**

1. Diagnosis of upper or lower limb spasticity (e.g., associated with paralysis, central nervous system demyelinating diseases such as multiple sclerosis, cerebral palsy, stroke);
2. Prescribed by or in consultation with a neurologist, orthopedist, or physiatrist;
3. Age ≥ 2 years;
4. Member meets one of the following (a, b, or c):
   a. For requests limited to the upper limb, failure of Xeomin® and Dysport® unless clinically significant adverse effects are experienced or both are contraindicated;
   b. For requests limited to the lower limb, failure of Dysport, unless contraindicated or clinically significant adverse effects are experienced;
   c. For requests involving both the upper and lower limbs, failure of Dysport, unless contraindicated or clinically significant adverse effects are experienced;
5. Member meets both of the following (a and b):
   a. Botox is not prescribed concurrently with other botulinum toxin products;
   b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
6. Treatment plan details number of Units per indication and treatment session;

7. Request meets one of the following (a or b):
    a. Age ≥ 18 years: Upper and/or lower limb: Dose does not exceed 400 Units per treatment session;
    b. Age 2 through 17 years (i, ii, and iii):
        i. Upper limb: Dose does not exceed the lower of 6 Units/kg body weight or 200 Units per treatment session;
        ii. Lower limb: Dose does not exceed the lower of 8 Units/kg body weight or 300 Units per treatment session.
        iii. If upper and lower limb spasticity are treated in the same treatment session, number of Units per treatment session does not exceed the lower of 10 Units/kg body weight or 340 Units per treatment session.

Approval duration:
Medicaid – 12 weeks (single treatment session)

D. Cervical Dystonia *(focal dystonia)* (must meet all):
1. Diagnosis of CD;
2. Prescribed by or in consultation with a neurologist, orthopedist, or physiatrist;
3. Age ≥ 16 years;
4. Member is 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. If age ≥ 18 years, failure of Xeomin and Dysport, unless clinically significant adverse effects are experienced or both are contraindicated;
7. Member meets both of the following (a and b):
    a. Botox is not prescribed concurrently with other botulinum toxin products;
    b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
8. Treatment plan details number of Units per indication and treatment session;
9. Request meets one of the following (a or b):
    a. Age ≥ 18 years: Dose does not exceed 100 Units total in the sternocleidomastoid (SCM) muscle and 300 Units per treatment session;
    b. Age 16 through 17 years: Dose does not exceed 100 Units total in the SCM muscle and the lower of 10 Units/kg body weight or 300 Units per treatment session.

Approval duration:
Medicaid – 12 weeks (single treatment session)

E. Primary Axillary Hyperhidrosis *(excessive underarm sweating)* (must meet all)**:**
1. Diagnosis of primary axillary hyperhidrosis;
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. Member meets both of the following (a and b):

   a. Botox is not prescribed concurrently with other botulinum toxin products;
   b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
6. Treatment plan details number of Units per indication and treatment session;
7. Dose does not exceed 100 Units per treatment session.

Approval duration:
Medicaid – 12 weeks (single treatment session)

F. Blepharospasm *(focal dystonia - abnormal eyelid muscle contraction)* (must meet all)***:***

1. Diagnosis of blepharospasm;
2. Prescribed by or in consultation with a neurologist or ophthalmologist;
3. Age ≥ 12 years;
4. Member is experiencing significant disability in daily functional activities due to interference with vision;
5. If age ≥ 18 years, failure of Xeomin, unless contraindicated or clinically significant adverse effects are experienced;
6. Member meets both of the following (a and b):
   a. Botox is not prescribed concurrently with other botulinum toxin products;
   b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
7. Treatment plan details number of Units per indication and treatment session;
8. Dose does not exceed 2.5 Units per muscle, 7.5 Units per eye, and 15 Units per treatment session.

Approval duration:
Medicaid – 12 weeks (single treatment session)

G. Strabismus *(eye misalignment)* (must meet all)**:**

1. Diagnosis of one of the following (a, b, or c):
   a. Vertical strabismus (superior and inferior rectus muscles, superior and inferior oblique muscles);
   b. Horizontal strabismus (medial and lateral rectus muscles) (i or ii):
      i. Horizontal strabismus < 20 prism diopters;
      ii. Horizontal strabismus 20 to 50 prism diopters;
   c. Persistent sixth cranial nerve (VI; abducens nerve) palsy of ≥ one month involving the lateral rectus muscle;
2. Prescribed by or in consultation with a neurologist or ophthalmologist;
3. Age ≥ 12 years;
4. Member meets both of the following (a and b):
   a. Botox is not prescribed concurrently with other botulinum toxin products;
   b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
5. Treatment plan details number of Units per indication and treatment session;
6. Request meets one of the following (a, b, or c):
   a. Vertical strabismus, or horizontal strabismus < 20 prism diopters: Dose does not exceed 2.5 Units per muscle and 5 Units per treatment session;

b. Horizontal strabismus 20 to 50 prism diopters: Dose does not exceed 5 Units per muscle and 10 Units per treatment session;
c. VI nerve palsy: Dose does not exceed 2.5 Units per treatment session (limited to treatment of one eye).

Approval duration:
Medicaid – 12 weeks (single treatment session)

H. Focal Dystonia and Essential Tremor (off-label) (must meet all):
1. Diagnosis of one of the following (a, b, c, or d):
   a. Laryngeal dystonia;
   b. Oromandibular dystonia (OMD);
   c. Upper extremity (UE) dystonia;
   d. UE essential tremor;
2. Prescribed by or in consultation with a neurologist, ENT specialist, orthopedist, or physiatrist;
3. Age meets one of the following (a or b):
   a. For UE dystonia: Age ≥ 2 years;
   b. For all other indications: Age ≥ 18 years;
4. For UE dystonia: Failure of a trial of carbidopa/levodopa or trihexyphenidyl *(see Appendix B)*, unless clinically significant adverse effects are experienced or both are contraindicated;
5. Member meets both of the following (a and b):
   a. Botox is not prescribed concurrently with other botulinum toxin products;
   b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
6. Treatment plan details number of Units per indication and treatment session;
7. Request meets one of the following (a or b):
   a. Laryngeal dystonia/OMD: Dose does not exceed 25 Units per treatment session;
   b. UE dystonia, UE essential tremor: Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use and member age (*prescriber must submit supporting evidence; Units per treatment session does not exceed the lower of 10 Units/kg body weight or 340 Units for pediatrics, or 400 Units for adults*).

Approval duration:
Medicaid – 12 weeks (single treatment session)

I. Esophageal Achalasia (off-label) (must meet all)**:**
1. Diagnosis of esophageal achalasia;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 18 years;
4. Member is not a candidate for pneumatic dilation or laparoscopic surgical myotomy (e.g., due to age, comorbidity);
5. Member meets both of the following (a and b):
   a. Botox is not prescribed concurrently with other botulinum toxin products;
   b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;

6. Treatment plan details number of Units per indication and treatment session;
7. Dose does not exceed 100 Units per treatment session.

Approval duration:
Medicaid – 12 weeks (single treatment session)

J. Hirschsprung Disease, Internal Anal Sphincter Achalasia (off-label) (must meet all):

1. Diagnosis of one of the following (a or b):
   a. Hirschsprung disease (HD) and (i or ii):
      i. Member has an HD subtype known as ultra-short segment HD;
      ii. Botox is prescribed for constipation post-surgery;
   b. Internal anal sphincter (IAS) achalasia;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age ≥ 2 years;
4. Failure of a trial of stool softeners and laxatives *(see Appendix B)*, unless clinically adverse effects are experienced or all are contraindicated;
5. Member meets both of the following (a and b):
   a. Botox is not prescribed concurrently with other botulinum toxin products;
   b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
6. Treatment plan details number of Units per indication and treatment session;
7. Dose does not exceed 100 Units per treatment session.

Approval duration:
Medicaid – 12 weeks (single treatment session)

K. Chronic Anal Fissure (off-label) (must meet all)**:**

1. Diagnosis of chronic anal fissure;
2. Prescribed by or in consultation with a gastroenterologist or colorectal surgeon;
3. Age ≥ 18 years;
4. Failure of nitroglycerin ointment and either oral/topical nifedipine or diltiazem *(see Appendix B)*, unless contraindicated or clinically significant adverse effects are experienced;
5. Member meets both of the following (a and b):
   a. Botox is not prescribed concurrently with other botulinum toxin products;
   b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
6. Treatment plan details number of Units per indication and treatment session;
7. Dose does not exceed 25 Units per treatment session.

Approval duration:
Medicaid – 12 weeks (single treatment session)

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.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. If receipt of ≥ 2 Botox treatment sessions, member has experienced and maintained a 30% reduction in monthly migraine headache frequency from baseline;
3. Botox is not prescribed concurrently with other botulinum toxin products;
4. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
5. Treatment plan details number of Units per indication and treatment session;
6. If request is for a dose increase, new dose does not exceed 155 Units per treatment session.

Approval duration:
Medicaid – 24 weeks (two 12-week treatment sessions)

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. Member meets all of the following (a, b, and c):
   a. Botox is not prescribed concurrently with other botulinum toxin products;
   b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
   c. If member has previously received ≥ 2 Botox treatment sessions for esophageal achalasia, it has been at least 24 weeks since the last treatment session;
4. Treatment plan details number of Units per indication and treatment session;
5. If request is for a dose increase, new dose does not exceed 100 Units per treatment session.

Approval duration:
Medicaid –

- 2nd treatment session: 12 weeks (single treatment session);
- 3rd treatment session and beyond: 24 weeks (single treatment session)

C. All Other Indications in Section I* (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. Member meets both of the following (a and b):
   a. Botox is not prescribed concurrently with other botulinum toxin products;
   b. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
4. Treatment plan details number of Units per indication and treatment session;
5. If request is for a dose increase, request meets one of the following (a through j):
   a. OAB: Dose does not exceed 100 Units per treatment session;
   b. Urinary incontinence associated with a neurologic condition: Dose does not exceed 200 Units per treatment session;

c. Upper/lower limb spasticity (i or ii):
   i. Age ≥ 18 years: Upper and/or lower limb: Dose not exceed 400 Units per treatment session;
   ii. Age 2 through 17 years (a, b, and c):
      a) Upper limb: Dose does not exceed the lower of 6 Units/kg body weight or 200 Units per treatment session;
      b) Lower limb: Dose does not exceed the lower of 8 Units/kg body weight or 300 Units per treatment session.
      c) If upper and lower limb spasticity are treated in the same treatment session, number of Units per treatment session does not exceed the lower of 10 Units/kg body weight or 340 Units per treatment session;

d. CD (i or ii):
   i. Age ≥ 18 years: Dose does not exceed 100 Units total in the SCM muscle and 300 Units per treatment session;
   ii. Age 16 through 17 years: Dose does not exceed 100 Units total in the SCM muscle and the lower of 10 Units/kg body weight or 300 Units per treatment session;

e. Primary axillary hyperhidrosis: Dose does not exceed 100 Units per treatment session;

f. Blepharospasm: Dose does not exceed 5 Units per muscle, 15 Units per eye, and 30 Units per treatment session;

g. Strabismus (i or ii):
   i. Vertical and horizontal strabismus: Dose does not exceed the lower of a two-fold increase or 25 Units per muscle and 50 Units per treatment session;
   ii. VI nerve palsy: Dose does not exceed the lower of a two-fold increase or 25 Units per muscle and 25 Units per treatment session;

h. Focal dystonia and essential tremor (i or ii):
   i. Laryngeal dystonia/OMD: Dose does not exceed 25 Units per treatment session;
   ii. UE dystonia, UE essential tremor: Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use and member age (*prescriber must submit supporting evidence; number of Units per treatment session does not exceed the lower of 10 Units/kg body weight or 340 Units for pediatrics, or 400 Units for adults*);

i. HD, IAS achalasia: Dose does not exceed 100 Units per treatment session;

j. Chronic anal fissure: Dose does not exceed 25 Units per treatment session.

Approval duration:
Medicaid – 12 weeks (single treatment session)

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.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.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);
- **C.** Episodic migraine (≤ 14 headache days per month): Safety and efficacy have not been established per the package insert;
- **D.** Total treatment dose per session does not exceed the lower of 10 Units/kg body weight or 340 Units in a 3-month interval for pediatrics and 400 Units for adults.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CD: cervical dystonia
CGRP: calcitonin gene-related peptide
FDA: Food and Drug Administration
HD: Hirschsprung disease
IAS: internal anal sphincter
MS: multiple sclerosis
NDO: neurogenic detrusor overactivity
OAB: overactive bladder
OMD: oromandibular dystonia
SCI: spinal cord injury
UE: upper extremity

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.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Overactive bladder, urinary incontinence		
oxybutynin (Ditropan®/XL, Gelnique®) *(anticholinergic agent)*	• Immediate-release tablets (adults and children): 5 mg orally two to three times daily • Extended-release tablets: 5-10 mg orally once daily • Topical gel: Apply contents of one sachet topically once daily	• Immediate-release: 20 mg/day • Extended-release: 30 mg/day • Gel: one sachet/day
tolterodine tartrate (Detrol®/LA) *(anticholinergic agent)*	• Immediate-release tablets: 2 mg orally twice daily • Extended-release tablets: 4 mg orally once daily	4 mg/day
solifenacin (Vesicare®) *(anticholinergic agent)*	• Adults and children weighing more than 60 kg: 5 mg PO once daily • Children weighing between 46 to 60 kg: 4 mg PO once daily	10 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	• Children weighing between 16 to 45 kg: 3 mg PO once daily • Children weighing between 9 to 15 kg: 2 mg once daily	
Myrbetriq® (mirabegron) *(beta-3 agonist)*	25 mg orally once daily	50 mg/day
Chronic migraine		
Examples of oral migraine preventive therapies - • Anticonvulsants: divalproex (Depakote®), topiramate (Topamax®) • Beta blockers: propranolol (Inderal®), metoprolol (Lopressor®), timolol • Antidepressants/tricyclic antidepressants: amitriptyline (Elavil®), venlafaxine (Effexor®)	*Refer to prescribing information for dosing regimens.*	*Refer to prescribing information*
Primary axillary hyperhidrosis		
Drysol® (aluminum chloride)	Apply topically once daily	One application/day
Dystonia		
carbidopa/levodopa (Sinemet®, Duopa®, Rytary®)	25 mg/100 mg PO QD, and increase by 1 tablet every 3 to 5 days.	1,200 mg/day of levodopa
trihexyphenidyl	30 mg PO QD	30 mg/day
Dysport® (abobotulinumtoxin A)	Cervical Dystonia: Divided among affected muscles every 12 weeks: Up to 1,000 Units IM	See dosing regimen
Xeomin® (incobotulinumtoxinA)	Cervical Dystonia: Up to 120 Units IM per treatment session every 12 weeks.	300 Units/12 weeks
HD, IAS achalasia		
Dulcolax® (bisacodyl)	5 to 15 mg PO or 10 mg PR QD	30 mg/day
MiraLax® (Polyethylene glycol 3350)	17 grams of polyethylene glycol 3350 in 4-8 oz water by mouth once daily	17 grams/day
Colace® (Docusate sodium)	50-200 mg PO QD-QID	200 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
Chronic anal fissure		
nitroglycerin 0.2% ointment (Rectiv®)	15 to 30 mg (2.5 to 5 cm as squeezed from the tube, about 1 to 2 inches), applied topically to skin every 8 hours while awake and at bedtime; application frequency 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 6 hours later	75 mg (12.5 cm as squeezed from the tube)/day
nifedipine or diltiazem (oral or topical ointment/gel-compounded)	PO: At provider discretion Intra-anal: 0.2% ointment or gel, applied around fissure(s) 2 times daily for 6-8 weeks	Varies
Blepharospasm		
Xeomin® (incobotulinumtoxinA)	Up to 50 Units IM per eye per treatment session every 12 weeks.	100 Units/12 weeks
Limb Spasticity		
Dysport® (abobotulinumtoxinA)	Adult upper and lower limb spasticity: Divided among affected muscles every 12 weeks: • Upper limb: Up to 1,000 Units IM • Lower limb: Up to 1,500 Units IM • Upper and lower limbs: Up to 1,500 Units IM staying within per limb guidelines Pediatric upper and lower limb spasticity: Divided among affected muscles every 12 weeks: • Upper limb: Up to the lower of 16 Units/kg/limb IM or 640 Units IM • Lower limb: Up to the lower of 15 Units/kg/limb IM or 1,000 Units IM • Bilateral lower limb: Up to the lower of 30 Units IM or 1,000 Units IM • Upper and lower limbs: Up to the lower of 30 Units IM or 1,000 Units IM staying within per limb guidelines	See dosing regimen
Xeomin® (incobotulinumtoxinA)	Upper limb spasticity: Up to 400 Units IM per treatment session every 12 weeks.	400 Units/12 weeks

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: Botulinum Toxin Product Interchangeability

- Potency Units of Botox are not interchangeable with other botulinum toxin product preparations (e.g., Dysport®, Myobloc®, Xeomin®).

Appendix E: Guideline Support for Botulinum Toxin Use

Indication	Guideline
Focal Dystonia* and Essential Tremor, and Headache	
Blepharospasm, cervical dystonia, adult spasticity, and headache	Academy of Neurology (2016)
Migraine prevention	American Academy of Neurology and the American Headache Society. Neurology (2012)
Laryngeal dystonia	American Academy of Otolaryngology-Head and Neck Surgery Foundation (2018)
Oromandibular dystonia	American Academy of Oral Medicine (2018)
Focal limb dystonia - UE**	American Academy of Neurology (2008)
Essential tremor - UE	American Academy of Neurology (2008)
Sialorrhea	American Academy of Cerebral Palsy and Developmental Medicine (AACPDM, 2018); International Parkinson and Movement Disorder Society (2018)
OAB/urinary incontinence	American Urological Association Society of Urodynamics (2019)
Gastrointestinal Conditions *(see guidelines for required oral medication information)*	
Esophageal achalasia	American College of Gastroenterology (2013)
HD and IAS achalasia	American Pediatric Surgical Association (2017)
Chronic anal fissure	American College of Gastroenterology (2014)

**American Academy of Neurology (AAN) classifies Botox use for hemifacial spasm and motor tics as category C, and notes that data are inadequate to make a recommendation for lower limb dystonia. All other AAN Botox recommendations above are classified as category B - probably effective.*

***Policy criteria requiring failure of oral medication for dystonias are limited to dystonias affecting the limbs (see Cloud and Jinnah, 2010).*

V. Dosage and Administration

<table>
<tr><th>Indication</th><th>Dosing Regimen</th><th>Maximum Dose</th></tr>
<tr><td>Adults: OAB</td><td>Up to 5 Units IM per injection across up to 20 injection sites in the detrusor muscle for a total of up to 100 Units per treatment session</td><td rowspan="10">See dosing regimens for maximum dose

Frequency:
• Esophageal acalasia: one treatment session every 24 weeks.
• All other indications: one treatment session every 12 weeks.</td></tr>
<tr><td>Pediatric NDO</td><td>• Weight ≥ 34 kg: 200 units
• Weight < 34 kg: 6 units/kg (see table below)
<table>
<tr><th>Body weight (kg)</th><th>Botox (mL)</th><th>Diluent (mL)</th><th>Final dose of Botox in dosing syringe</th></tr>
<tr><td>12 to > 14 kg</td><td>3.6</td><td>6.4</td><td>72 units</td></tr>
<tr><td>14 to < 16 kg</td><td>4.2</td><td>5.8</td><td>84 units</td></tr>
<tr><td>16 to < 18 kg</td><td>4.8</td><td>5.2</td><td>96 units</td></tr>
<tr><td>18 to < 20 kg</td><td>5.4</td><td>4.6</td><td>108 units</td></tr>
<tr><td>20 to < 22 kg</td><td>6</td><td>4</td><td>120 units</td></tr>
<tr><td>22 to < 24 kg</td><td>6.6</td><td>3.4</td><td>132 units</td></tr>
<tr><td>24 to < 26 kg</td><td>7.2</td><td>2.8</td><td>144 units</td></tr>
<tr><td>26 to < 28 kg</td><td>7.8</td><td>2.2</td><td>156 units</td></tr>
<tr><td>28 to < 30 kg</td><td>8.4</td><td>1.6</td><td>168 units</td></tr>
<tr><td>30 to < 32 kg</td><td>9</td><td>1</td><td>180 units</td></tr>
<tr><td>32 to < 34 kg</td><td>9.6</td><td>0.4</td><td>192 units</td></tr>
</table></td></tr>
<tr><td>Adults: urinary incontinence associated with neurologic condition</td><td>Up to approximately 6.7 Units IM per injection across up to 30 injection sites in the detrusor muscle for a total of up to 200 Units per treatment session</td></tr>
<tr><td>Adults: chronic migraine</td><td>Up to 5 Units IM per injection across up to 7 head/neck muscles for a total of up to 155 Units per treatment session</td></tr>
<tr><td>Adults: upper and lower limb spasticity</td><td>Up to 50 Units IM per injection and up to 400 Units per treatment session</td></tr>
<tr><td>Pediatrics: upper and limb spasticity</td><td>• Upper limb spasticity: Up to the lower of 6 Units/kg or 200 Units IM per treatment session
• Lower limb spasticity: Up to the lower of 8 Units/kg or 300 Units IM per treatment session
• Upper and lower limb spasticity: Up to the lower of 10 Units/kg or 340 Units IM per treatment session</td></tr>
<tr><td>Adults: CD</td><td>Up to 50 Units IM per injection, 100 Units total in the sternocleidomastoid (SCM) muscle, and 300 Units per treatment session</td></tr>
<tr><td>Pediatrics: CD</td><td>Up to 50 Units IM per injection, 100 Units total in the SCM muscle, and the lower of 10 Units/kg body weight or 300 Units per treatment session</td></tr>
</table>

Indication	Dosing Regimen	Maximum Dose
Adults: axillary hyperhidrosis	Up to 50 Units IM per axilla per treatment session	
Adults and pediatrics: blepharospasm	• Botox naive: Up to 2.5 Units IM per muscle, 7.5 Units per eye, and 15 Units per treatment session • Botox experienced: Up to 5 Units IM per muscle, 15 Units per eye, and 30 Units per treatment session	
Adults and pediatrics: strabismus	• Botox naive: ○ Vertical muscles, or horizontal strabismus < 20 prism diopters: Up to 2.5 Units IM per muscle and 5 Units per treatment session ○ Horizontal strabismus 20 to 50 prism diopters: Up to 5 Units IM per muscle and 10 Units per treatment session ○ VI nerve palsy: 2.5 Units IM in the medial rectus muscle and 2.5 Units per treatment session • Botox experienced: ○ Vertical and horizontal strabismus: Up to the lower of a two-fold increase or 25 Units IM per muscle and 50 Units per treatment session ○ VI nerve palsy: Up to the lower of a two-fold increase or 25 Units IM per muscle and 25 Units per treatment session	
Off-label uses		
Laryngeal dystonia	Up to 25 Units IM per treatment session. *(Off-label - Micromedex 2020)*	
UE dystonia UE essential tremor	Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use and member age (prescriber must submit supporting evidence; number of Units per treatment session does not exceed the lower of 10 Units/kg body weight or 340 Units IM for pediatrics, or 400 Units IM for adults).	
OMD	Up to 25 Units IM per treatment session. *(Off-label - Hallet 2009)*	
Esophageal achalasia	Up to 100 Units IM per treatment session. *(Off-label - Vaezi 2013)*	
HD, IAS achalasia	Up to 100 Units IM per treatment session. *(Off-label - Langer 2017)*	
Chronic anal fissure	Up to 25 Units IM per treatment session. *(Off-label - Micromedex 2020)*	

VI. Product Availability

Vials: 100 Units, 200 Units

VII. References

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Overactive Bladder, Urinary Incontinence

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Migraine, Spasticity, Dystonia, Tremor

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6. Cloud LJ, Jinnah HA. Treatment strategies for dystonia. Expert Opin Pharmacother 2010; 11(1):5-15.
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Esophageal Achalasia

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Hirschsprung Disease, Internal Anal Sphincter Achalasia

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Chronic Anal Fissure

14. Wald A, Bharucha AE, Cosman BC, et al. American College of Gastroenterology clinical guideline: Management of benign anorectal disorders. Am J Gastroenterol 2014; 109:1141–1157; doi: 10.1038/ajg.2014.190; published online 15 July 2014.

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
J0585	Injection, onabotulinumtoxinA, 1 unit

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.23	01.23

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.