



Pharmacy Medical Policy Anti-Parkinsonism Drugs

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Policy Number: 054

BCBSA Reference Number: N/A

Related Policies

- N/A

Prior Authorization Information

Policy	<input type="checkbox"/> Prior Authorization <input checked="" type="checkbox"/> Step Therapy <input type="checkbox"/> Quantity Limit	Reviewing Department Policy Effective Date	Pharmacy Operations: Tel: 1-800-366-7778 Fax: 1-800-583-6289 2/2025
Pharmacy (Rx) or Medical (MED) benefit coverage	<input checked="" type="checkbox"/> Rx <input type="checkbox"/> MED	To request for coverage: Providers may call, fax, or mail the attached form (Formulary Exception/Prior Authorization form) to the address below.	
Policy applies to Commercial Members: <ul style="list-style-type: none"> Managed Care (HMO and POS), PPO and Indemnity MEDEX with Rx plan Managed Major Medical with Custom BCBSMA Formulary Comprehensive Managed Major Medical with Custom BCBSMA Formulary Managed Blue for Seniors with Custom BCBSMA Formulary Policy does NOT apply to: <ul style="list-style-type: none"> Medicare Advantage 		Blue Cross Blue Shield of Massachusetts Pharmacy Operations Department 25 Technology Place Hingham, MA 02043 Tel: 1-800-366-7778 Fax: 1-800-583-6289 Individual Consideration for the atypical patient: Policy for requests that do not meet clinical criteria of this policy, see section labeled Individual Consideration	

Summary

This is a comprehensive policy covering step therapy requirements for anti-Parkinsonism medications.

Policy

Length of Approval	24 months
Formulary Status	All requests must meet the Step Therapy requirement and for non-covered medications, the member must also have had a previous treatment failure with, or contraindication to, at least two covered formulary alternatives when available. See section on individual consideration for more information if you require an exception to any of these criteria requirements for an atypical patient.
Member cost share consideration	A higher non-preferred cost share may be applied if an exception request is approved for coverage of a non-preferred or a non-formulary/non-covered drug.

The step therapy requirements for "off" episode medications:

Drug	Formulary Status (BCBSMA Commercial Plan)	Step Requirement
Step 1		
Carbidopa/Levodopa (Generics for all strengths & dosage forms)	Covered	Covered with no requirements
Duopa Suspension	Covered	
Step 2		
Inbrija™ (levodopa inhalation powder)	ST	Requires prior use of a step 1 medication OR history of prior use of any step 2 medication in this table within the previous 130 days. See below for prior use criteria.
Nourianz® (istradefylline) Tablets	ST	

ST – Step Therapy

The step therapy requirements for Catechol-O-methyltransferase (COMT) inhibitors:

Drug	Formulary Status (BCBSMA Commercial Plan)	Step Requirement
Step 1		
entacapone	Covered	Covered with no requirements
Step 2		
Ongentys® (opicapone)	ST	Requires prior use of a step 1 medication OR history of prior use of any step 2 medication in this table within the previous 130 days. See below for prior use criteria.
Comtan® (entacapone)	ST	
Tasmar® (tolcapone)	ST	
tolcapone	ST	

ST – Step Therapy

Prior Use of Criteria

The plan uses prescription claim records to support criteria for prior use within previous 130 days or the trial and failure of formulary alternatives when available. Additional documentation will be required from the provider when historic prescription claim data is either not available or the medication fill history fails to establish criteria for prior use or trial and failure of formulary alternatives. Documentation will also be required to support any clinical reasons preventing the trial and failure of formulary alternatives. Please see the section on documentation requirements for more information.

Provider Documentation Requirements

Documentation from the provider to support a reason preventing trial of formulary alternative(s) must include the name and strength of alternatives tried and failed (if alternatives were tried, including dates if available) and specifics regarding the treatment failure. Documentation to support clinical basis preventing switch to formulary alternative should also provide specifics around clinical reason.

Individual Consideration (For Atypical Patients)

Our medical policies are written for most people with a given condition. Each policy is based on peer reviewed clinical evidence. We also take into consideration the needs of atypical patient populations and diagnoses.

If the coverage criteria outlined is unlikely to be clinically effective for the prescribed purpose, the health care provider may request an exception to cover the requested medication based on an individual's unique clinical circumstances. This is also referred to as "individual consideration" or an "exception request."

Some reasons why you may need us to make an exception include: therapeutic contraindications; history of adverse effects; expected to be ineffective or likely to cause harm (physical, mental, or adverse reaction).

To facilitate a thorough and prompt review of an exception request, we encourage the provider to include additional supporting clinical documentation with their request. This may include:

- Clinical notes or supporting clinical statements;
- The name and strength of formulary alternatives tried and failed (if alternatives were tried) and specifics regarding the treatment failure, if applicable;
- Clinical literature from reputable peer reviewed journals;
- References from nationally recognized and approved drug compendia such as American Hospital Formulary Service® Drug Information (AHFS-DI), Lexi-Drug, Clinical Pharmacology, Micromedex or Drugdex®; and
- References from consensus documents and/or nationally sanctioned guidelines.

Providers may call, fax or mail relevant clinical information, including clinical references for individual patient consideration, to:

Blue Cross Blue Shield of Massachusetts
Pharmacy Operations Department
25 Technology Place
Hingham, MA 02043
Phone: 1-800-366-7778
Fax: 1-800-583-6289

We may also use prescription claims records to establish prior use of formulary alternatives or to show if step therapy criteria has been met. We will require the provider to share additional information when prescription claims data is either not available or the medication fill history fails to establish use of preferred formulary medications or that step therapy criteria has been met.

Policy History

Date	Action
5/2025	Removed Vyalev. Medical Benefit only.
2/2025	Updated to add Vyalev to Step 2 in the first table in the policy.
9/2023	Reformatted Policy. Updated IC section to align with 118E MGL § 51A.
7/2023	Reformatted Policy.
1/2021	Updated to add Ongentys and other COMT inhibitors in a new Step table.
1/2020	Updated to add Nourianz [™] to the policy.
4/2019	Implementation of a new Step policy.

Forms

To request prior authorization using the Massachusetts Standard Form for Medication Prior Authorization Requests (eForm), click the link below:

Massachusetts Standard Form for Medication Prior Authorization Requests [#434](#)

References

1. Inbrija [™] [package insert]. Ardsley, NY: Acorda Therapeutics, Inc.: 1/2019.
2. Nourianz [™] [package insert]. Bedminster, NJ: Kyowa Kirin, Inc.: 9/2019.
3. Ongentys [®] [package insert]. San Diego, CA: Neurocrine Biosciences, Inc.: 4/2020.
4. Comtan [®] [package insert]. East Hanover, N.J: Novartis Pharmaceuticals Corporation.: 12/2019.
5. Tasmar [®] [package insert]. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC: 12/2018.