MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Pharmacy Medical Policy

Anti-Parkinsonism Drugs

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Policy Number: 054

BCBSA Reference Number: N/A

Related Policies:

None

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Note: All requests for outpatient retail pharmacy for indications listed and not listed on the medical policy guidelines may be submitted to BCBSMA Clinical Pharmacy Operations by completing the Prior Authorization Form on the last page of this document. Physicians may also call BCBSMA Pharmacy Operations department at (800)366-7778 to request a prior authorization/formulary exception verbally. Patients must have pharmacy benefits under their subscriber certificates.

Please refer to the chart below for the formulary and step status of the medications affected by this policy.

"Off" Episodes Step Table	Formulary Information Standard Formulary Status
STEP 1	
Carbidopa/Levodopa (Generics for all strengths & dosage forms)	Covered
Duopa Suspension	
STEP 2	
Inbrija™ (levodopa inhalation powder)	Prior use of Step 1 Required
Nourianz® (istradefylline) Tablets	

COMT inhibitor Step Table	Formulary Information Standard Formulary Status
STEP 1	
entacapone	Covered
STEP 2	
Ongentys® (opicapone)	Prior use of Step 1 Required
Comtan® (entacapone)	
Tasmar® (tolcapone)	
tolcapone	

We may cover the Anti-Parkinsonism drugs listed in the chart above for new starts* in the following stepped approach.

*New start is defined as no previous paid claim for the requested medication within the past 130 days

Step 1: Step 1 medications will be covered without prior authorization.

Step 2: Step 2 medications may be covered when **one** of the following criteria are met:

- There must be evidence of a BCBSMA paid claim by the patient of a step 1 medication within the previous 130 days.
  OR
- There must be evidence of a BCBSMA paid claim by the patient of a step 2 medication within the previous 130 days. If the Medication is Not Covered/Non-formulary the drug needs to meet the requirements of Formulary Exception for continued coverage.

** Non-formulary medications are covered when a formulary exception request is submitted to BCBSMA Pharmacy Operations and requires **TWO** formulary drugs to be tried prior to granting a Formulary Exception (FE).

Note:*Exception requests based exclusively on the use of samples will not meet coverage criteria for non-formulary medications. Additional clinical information demonstrating medical necessity of the non-formulary medication must be submitted by the requesting prescriber for review.

We do not cover drugs listed in the above chart unless the above step therapy criteria are met.

CPT Codes / HCPCS Codes / ICD-9 Codes

The following codes are included below for informational purposes. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

There is no specific CPT code for this service.

Individual Consideration

All our medical policies are written for the majority of people with a given condition. Each policy is based on medical science. For many of our medical policies, each individual's unique clinical circumstances may be considered in light of current scientific literature. Physicians may send relevant clinical information for individual patients for consideration to:

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

Prior Authorization Information

Outpatient

For services described in this policy, see below for products where prior authorization **IS REQUIRED** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required**.
Commercial PPO and Indemnity	Prior authorization is **required**.

Policy History

Date	**Action**
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.

References

1. Inbrija™ [package insert]. Ardsley, NY: Acorda Therapeutics, Inc.: 1/2019.
2. Nourianz™ [package insert]. Bedminster, NJ: Kyowa Kirin, Inc.: 9/2019.
3. Ogentys® [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.

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

http://www.bluecrossma.org/medical-policies/sites/g/files/csphws2091/files/acquiadam-assets/023%20E%20Form%20medication%20prior%20auth%20instruction%20prn.pdf