BlueCross BlueShield of Arizona
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PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 9/15/17**
SECTION: DRUGS	**LAST REVIEW DATE: 9/20/18**
	LAST CRITERIA REVISION DATE: 9/20/18
	ARCHIVE DATE:

RYTARY™ (carbidopa and levodopa) extended-release oral capsule
TASMAR® (tolcapone) oral tablet
ZELAPAR (selegiline hydrochloride) orally disintegrating tablet

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

Rytary (carbidopa and levodopa, extended release)

Criteria:

- **Criteria for initial therapy:** Rytary (carbidopa/levodopa ER) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual is 18 years of age or older
  2. A confirmed diagnosis of Parkinson's disease
  3. Tried, failed, or has contraindication to use of generic extended-release **Carbidopa/Levodopa** tablets
  4. There are no contraindications such as use with or within 14 days of stopping isocarboxazid, phenelzine, or tranycypromine

  Initial approval duration: 12 months

- **Criteria for continuation of coverage (renewal request):** Rytary (carbidopa/levodopa ER) is considered ***medically necessary*** and will be approved with documentation of **ALL** of the following:

  1. Individual's condition responded while on therapy
  2. Individual has been adherent with the medication
  3. Individual has not developed any contraindications or other significant level 4 adverse drug effects that may exclude continued use
  4. There are no significant interacting drugs

  Renewal duration: 12 months

Tasmar (tolcapone)

Criteria:

- **Criteria for initial therapy:** Tasmar (tolcapone) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual is 18 years of age or older

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2. Requires continued use of carbidopa and levodopa

3. Individual experiencing symptom fluctuations

4. Individual is not responding to or not a candidate for other adjunctive therapy for Parkinson's disease

5. Tried, failed, or has contraindication to use of generic tolcapone and entacapone (brand and generic)

6. **ALL** of the following baseline tests have been completed before initiation of treatment with continued monitoring as clinically appropriate:
   - Liver function tests

7. There are no contraindications such as liver disease, individuals who were withdrawn from Tasmar due to hepatic injury, history of non-traumatic rhabdomyolysis, or hyperpyrexia and confusion related to medication

Initial approval duration: 2 months

- **Criteria for continuation of coverage (renewal request):** Tasmar (tolcapone) is considered ***medically necessary*** and will be approved with documentation of **ALL** of the following:

1. Individual's condition responded while on therapy
   - Response is defined as **ONE** of the following:
     - Achieved and maintains a reduction in symptom fluctuations
     - Achieved and maintains at least 1.5-2 hours more of relatively good functioning
     - Achieved and maintains at least 1 hour less of relatively poor functioning

2. Individual has been adherent with the medication

3. Individual has not developed any contraindications or other significant level 4 adverse drug effects that may exclude continued use, such as:
   - Any of the contraindication listed above
   - Hepatotoxicity toxicity, exhibited by elevation of ALT and AST that are > 2x ULN or clinical symptoms

4. There are no significant interacting drugs

Renewal duration: 12 months

Zelapar (selegiline) ODT

Criteria:

- **Criteria for initial therapy:** Zelapar (selegiline) ODT is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Individual is 18 years of age or older
  2. Requires continued use of carbidopa and levodopa
  3. Individual is experiencing deterioration in the quality of the response to therapy
  4. Tried, failed, or has sontraindication to use of generic selegiline tablets and capsules
  5. There are no contraindications
     - Contraindication include:
       - Hypersensitivity to Selegiline
       - Concurrent use with cyclobenzaprine, dextromethorphan, or St. John's wort
       - Concurrent use with or within 14 days of stopping **ANY** of the following:
         - Methadone
         - Meperidine
         - Propoxyphene
         - Tramadol
         - Isocarboxazid
         - Phenelezine
         - Tranylcypromine
         - Azilect (rasagiline)
         - Other Selegiline products

  Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Zelapar (selegiline) is considered ***medically necessary*** and will be approved with documentation of **ALL** of the following:

  1. Individual's condition responded has responded while on therapy
     - Response is defined as **ONE** of the following:
       - Achieved and maintains a reduction in symptom fluctuations
       - Achieved and maintains at least 1- 1.5 hours less of relatively poor functioning
  2. Individual has been adherent with the medication

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3. Individual has not developed any contraindications or other significant level 4 adverse drug effects that may exclude continued use, such as:
    - Any of the contraindication listed above
    - Serotonin syndrome
    - Hypertensive crisis

4. There are no significant interacting drugs

Renewal duration: 12 months

Description:

Rytary (carbidopa/levodopa) extended release capsule is indicated **for the treatment of Parkinson's disease (PD), post-encephalitic parkinsonism, and parkinsonism that may follow carbon monoxide intoxication or manganese intoxication**. **Tasmar (tolcapone)** tablet is indicated as an **adjunct to carbidopa and levodopa for the treatment of signs and symptoms of idiopathic PD in patients who are experiencing symptom fluctuations and are not responding satisfactorily to or are not appropriate candidates for other adjunctive therapies**. **Zelapar (selegiline) oral disintegrating tablet** is indicated as an **adjunct in the management of patients with PD being treated with carbidopa/levodopa who exhibit deterioration in the quality of their response** to this therapy.

Motor symptoms of PD are caused by a progressive degeneration of Dopamine (DA) containing neurons in the brain. Non-motor manifestations such as cognitive and psychiatric symptoms are thought to be due to degeneration of other neurotransmitter systems within the brain. Degeneration of the DA neurons leads to DA deficiency and as a result the development of the classic triad of motor symptoms of resting tremor, muscle rigidity and bradykinesia. With the development of DA deficiency, there is also a relative excess of acetylcholine activity.

Drug therapy is targeted at reducing symptoms by enhancing the effects of DA or inhibiting the effects of acetylcholine. Levodopa has been long recognized in clinical practice guidelines and texts as the standard of care for PD. It is a precursor of DA and is able to cross the blood brain barrier where it is converted to DA. Levodopa is thought to be protective against the dopaminergic neuron damage observed in PD. Levodopa is converted to DA in the periphery before it is able to cross the blood brain barrier resulting in gastrointestinal adverse effects and a lower than expected concentration of levodopa within the brain. To avoid this, levodopa is combined with carbidopa resulting in a decrease in the peripheral conversion of levodopa to DA and allowing for more levodopa to reach the brain to then be converted to DA. The combination of carbidopa/levodopa is one of the most effective treatments available for symptomatic relief of PD.

Other treatments include DA receptor agonists, catechol-O-methyl-transferase (COMT) inhibitors, selective mono-amine oxidase type-B (MAOI-B) inhibitors, Amantadine, and selective use of anticholinergic agents. These agents are effective and safe in controlling motor symptoms in patients with advanced PD when used as adjunctive treatment to Levodopa. There is insufficient evidence to conclude that any one of these medications is clinically

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superior to another and there is insufficient evidence that shows one PD medication as superior to another in terms of improvement in functional outcomes.

Low cost generic options are available in immediate and extended-release formulations of carbidopa/levodopa as well as for each class of adjunctive therapy and are sufficient to meet the needs of most patients.

Definitions:

Oral Anti-Parkinson's disease agents	
Carbidopa	Carbidopa generic tabs Lodosyn tabs
Carbidopa+Levodopa	Carbidopa+Levodopa – immediate release generic tabs Carbidopa+Levodopa ER – extended release generic tabs Carbidopa+Levodopa ODT generic tabs Rytary – extended release caps Sinemet – immediate release tabs Sinemet CR – extended release tabs
Carbidopa+Levodopa+Entacapone	Carbidopa+Levodopa+Entacapone generic tabs Stalevo tabs
COMT inhibitors	Entacapone generic tabs Comtan (entacapone) tabs Tolcapone generic tabs Tasmar (tolcapone) tabs
DA agonists	Bromocriptine generic tabs Parlodel (bromocriptine) tabs Pramipexole – immediate release generic tabs Pramipexole ER – extended release generic tabs Mirapex (pramipexole) – immediate release tabs Mirapex ER (pramipexole) – extended release tabs Ropinirole – immediate release generic tabs Ropinirole ER – extended release generic tabs Requip (ropinirole) – immediate release tabs Requip XL(ropinirile) – extended release tabs

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MAO-B inhibitors	Rasagiline generic tabs Azilect (rasagiline) tabs Xadago (safinamide) tabs Selegiline generic tabs and caps Eldedryl (selegiline) caps Zelapar (selegiline) – ODT tab
Anticholinergic agents for PD	Benztropine Diphenhydramine Trihexyphenidyl

The Child-Pugh classification system:

	Score: 1 point	**Score: 2 points**	**Score: 3 points**
Serum Albumin (g/dL)	>3.5	3.0 - 3.5	<3.0
Serum Bilirubin (mg/dL)	<2.0	2.0 - 3.0	>3.0
Prothrombin time (seconds)	1 - 4	4 - 6	>6
Ascites	none	moderate	severe
Encephalopathy	none	mild	severe

The three classes and their scores are:
- **Class A** is score 5 – 6: Well compensated
- **Class B** is score 7 – 9: Significant functional compromise
- **Class C** is score >9: Decompensated disease

Resources:

Rytary. Package Insert. Revised by manufacturer 11/2016. Accessed 07-19-2018.

Rytary. Package Insert. Revised by manufacturer 04/2016. Accessed 08-09-2016.

Rytary. Package Insert. Reference ID 3680199. Revised by manufacturer 01/2015. Accessed 07/22/15, 07/22/16.

Tasmar. Package Insert. Revised by manufacturer 1/2017. Accessed 07-19-2018.

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Tasmar. Package Insert. Revised by manufacturer 11/2013. Accessed 07-22-2015.

Tasmar. Package Insert. Revised by manufacturer 8/2015. Accessed 07-22-2016.

Zelapar. Package Insert. Revised by manufacturer 8/2016. Accessed 07-19-2018.

Zelapar. Package Insert. Revised by manufacturer 07/2014. Accessed 07-22-2015, 07-22-2016.

UpToDate: Motor fluctuations and dyskinesia in Parkinson disease. Current through Aug 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/motor-fluctuations-and-dyskinesia-in-parkinson-disease?source=search_result&search=parkinsons%20disease%20adult&selectedTitle=13~150#H3

UpToDate: Pharmacologic treatment of Parkinson disease. Current through Aug 2017. https://www-uptodate-com.mwu.idm.oclc.org/contents/pharmacologic-treatment-of-parkinson-disease?source=search_result&search=parkinsons%20disease%20adult&selectedTitle=2~150

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:		Dosage Form:
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. **What is the diagnosis? Please specify below.**

   ICD-10 Code: _____ **Diagnosis Description:** _____

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. **Are there any supporting labs or test results? Please specify below.**

Date	Test	Value

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6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.