Pharmacy Medical Necessity Guidelines: Inbrija (levodopa)

Effective: April 14, 2020

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	Rx	Department to Review	RxUM

These pharmacy medical necessity guidelines apply to the following:

Commercial Products

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

Tufts Health Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☐ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan

Fax Numbers:
RXUM: 617.673.0988

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

Inbrija (levodopa) is an aromatic amino acid indicated for the intermittent treatment of "off" episodes in patients with Parkinson's disease treated with carbidopa/levodopa.

Inbrija (levodopa) capsules contain levodopa inhalation powder and are for oral inhalation only. Inbrija must be used with Inbrija inhaler.

COVERAGE GUIDELINES

The plan may authorize coverage of Inbrija (levodopa) when all of the following criteria are met:

1. The member has a diagnosis of Parkinson's disease

AND

2. One of the following:
   a. The member is currently taking a controlled or extended release formulation of carbidopa/levodopa
   b. The member is currently taking an immediate release formulation of carbidopa/levodopa and there is documentation of inadequate response, contraindication, or inability to tolerate a long acting formulation (e.g. extended release, controlled release) of carbidopa/levodopa

AND

3. The member is experiencing intermittent "off" episodes of more than 2 hours daily, related to Parkinson's Disease

AND

4. The member has had previous treatment with or has a contraindication or intolerance to one agent from two out of three therapeutic classes listed below:
   i. A dopamine agonist (e.g. pramipexole IR, ropinirole IR)
   ii. A monoamine oxidase-B (MAO-B) inhibitor (e.g. selegiline),
   iii. A catechol-O-methyltransferase (COMT) inhibitor (e.g. entacapone)

AND

5. Carbidopa/levodopa therapy will be continued concomitantly with Inbrija

LIMITATIONS

None

CODES

None

REFERENCES

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APPROVAL HISTORY

July 09, 2019: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:
1. April 14, 2020: Effective April 14, 2020 Inbrija MNG applies to MA and RITogether plans only. Inbrija criteria has been added to Medications for the Management of Parkinson's Disease MNG (ID: 6546248) for Commercial and Direct Plans. No criteria changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.