

Pharmacy Medical Necessity Guidelines: Metaxalone

Effective: March 16, 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 <input type="checkbox"/> Tufts Health Plan Commercial products – large group plans <input type="checkbox"/> Tufts Health Plan Commercial products – small group and individual plans <input type="checkbox"/> Tufts Health Freedom Plan products – large group plans <input type="checkbox"/> Tufts Health Freedom Plan products – small group plans <ul style="list-style-type: none"> • CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization Tufts Health Public Plans Products <input type="checkbox"/> Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product) <input type="checkbox"/> Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans <input checked="" type="checkbox"/> 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

FDA-APPROVED INDICATIONS

Skelaxin[®] (metaxalone) is indicated as an adjunct to rest, physical therapy, and other measures for the relief of discomforts associated with acute, painful musculoskeletal conditions. The mode of action of this drug has not been clearly identified, but may be related to its sedative properties.

COVERAGE GUIDELINES

The plan may authorize coverage of Skelaxin[®] (metaxalone) for Members when one of the following criteria is met and limitations do not apply:

1. The Member has tried and failed therapy with two generic skeletal muscle relaxants on the Preferred Drug List, or the Member has a contraindication to two alternative generic muscle relaxant on the Preferred Drug List
- OR**
2. The provider indicates a concern with potential adverse effects, such as dizziness or drowsiness, with the available generic skeletal muscle relaxants

LIMITATIONS

1. Approval is limited to generic metaxalone. Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria.

CODES

None

REFERENCES

1. Skelaxin (metaxalone) [prescribing information]. Bristol, TN: King Pharmaceuticals, Inc.; March 2018.
2. Van Tulder MW, Touray T, Furlan AD, et al. Muscle relaxants for non-specific low back pain. Cochrane Database Syst Rev 2003; CD004252.
3. Beebe FA, Barkin RL, Barkin S. A clinical and pharmacologic review of skeletal muscle relaxants for musculoskeletal conditions. Am J Ther 2005; 12:151.
4. Chou R, Peterson K, Helfand M. Comparative efficacy and safety of skeletal muscle relaxants for spasticity and musculoskeletal conditions: a systematic review. J Pain Symptom Manage 2004; 28:140.

APPROVAL HISTORY

April 17, 2008: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. September 9, 2014: No changes
2. September 16, 2015: No changes

3. January 1, 2016: Administrative change to rebranded template
4. September 13, 2016: No changes
5. May 9, 2017: Administrative update. Effective 6/1/2017, Medical Necessity Guideline applies to Tufts Health RITogether
6. September 12, 2017: No changes
7. October 16, 2018: Administrative changes made to template
8. April 9, 2019: No changes
9. March 10, 2020: Effective March 16, 2020, administrative update, updated the title of the MNG from "Skelaxin" to "Metaxalone"

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.

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