



PREFERRED SPECIALTY MANAGEMENT POLICY

- POLICY:** Vesicular Monoamine Transporter Type 2 Inhibitors Preferred Specialty Management Policy
- Xenazine® (tetrabenazine tablets – Lundbeck, generic)

REVIEW DATE: 06/07/2023

INSTRUCTIONS FOR USE

THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Tetrabenazine, a reversible vesicular monoamine transporter type 2 (VMAT2) inhibitor, is indicated for the treatment of **chorea associated with Huntington's disease**.¹

Clinical Efficacy

There are several published studies which have assessed the efficacy and safety of tetrabenazine for the treatment of other hyperkinetic movement disorders (e.g., tics in Tourette syndrome and tardive dyskinesia).²

POLICY STATEMENT

This Preferred Specialty Management program has been developed to encourage the use of the Preferred Product. For all medications (Preferred and Non-Preferred), the patient is required to meet the standard *Vesicular Monoamine Transporter Type 2 Inhibitors Prior Authorization Policy* criteria. The program also directs the patient to try the Preferred Product (generic tetrabenazine tablets). Requests for Non-Preferred Products will also be reviewed using the exception criteria (below). If the patient meets the standard *Prior Authorization Policy* criteria

but has not tried a Preferred Product, approval for a Preferred Product will be authorized. All approvals are provided for 1 year.

Documentation: Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and/or other information.

Preferred Product: Generic tetrabenazine tablets
Non-Preferred Product: Xenazine

Vesicular Monoamine Transporter Type 2 Inhibitors non-preferred product(s) is(are) covered as medically necessary when the following non-preferred product exception criteria is(are) met. Any other exception is considered not medically necessary.

NON-PREFERRED PRODUCT EXCEPTION CRITERIA

Non-Preferred Product	Exception Criteria
Xenazine	<ol style="list-style-type: none"> 1. Patient meets the following criteria (A <u>and</u> B): <ol style="list-style-type: none"> A) Patient meets the standard <i>Vesicular Monoamine Transporter Type 2 Inhibitor – Tetrabenazine Prior Authorization Policy</i> criteria; AND B) Patient meets both of the following criteria (i <u>and</u> ii): <ol style="list-style-type: none"> i. Patient tried generic tetrabenazine tablets; AND ii. Patient cannot continue to use the Preferred medication due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the generic product which, per the prescribing physician, would result in a significant allergy or serious adverse reaction. [documentation required]. 2. If the patient has met the standard <i>Vesicular Monoamine Transporter Type 2 Inhibitor – Tetrabenazine Prior Authorization Policy</i> criteria (1A), but has <u>not</u> met exception criteria (1B) above for brand Xenazine: approve generic tetrabenazine tablets.

REFERENCES

1. Xenazine® tablets [prescribing information]. Deerfield, IL: Lundbeck; September 2017.
2. Merative Micromedex®. Merative US. Available at: www.micromedexsolutions.com. Accessed on June 2, 2023. Search terms: tetrabenazine.

History

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	06/08/2022
Annual Revision	No criteria changes.	06/07/2023

"Cigna Companies" refers to operating subsidiaries of Cigna Corporation. All products and services are provided exclusively by or through such operating subsidiaries, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. © 2023 Cigna