Cigna National Formulary Coverage Policy



Prior Authorization Parkinson's Disease – Nourianz® (istradefylline tablets)

Table of Contents

Product Identifier(s)

Effective through 12/31/2022: 75129 Effective 1/1/2023: 109156

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.

National Formulary Medical Necessity

Cigna covers istradefylline (Nourianz®) as medically necessary when the following criteria are met for FDA Indications or Other Uses with Supportive Evidence:

Prior Authorization is recommended for prescription benefit coverage of Nourianz. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of individuals treated with Nourianz as well as the monitoring required for adverse events and long-term efficacy, approval requires Nourianz to be prescribed by or in consultation with a physician who specializes in the condition being treated.

FDA Indication(s)

- 1. Parkinson's Disease. Approve Nourianz for 1 year if individual meets the following criteria (A. B. and C):
 - A) Individual is currently taking carbidopa/levodopa; AND
 - B) Individual is experiencing "off" episodes such as muscle stiffness, slow movements, or difficulty starting movements. AND
 - C) Nourianz is prescribed by or in consultation with a neurologist.

Conditions Not Covered

Istradefylline (Nourianz®) is considered experimental, investigational or unproven for ANY other use.

Background

Overview

Nourianz, an adenosine receptor antagonist, is indicated as adjunctive treatment to carbidopa/levodopa in adults with **Parkinson's disease** experiencing "off" episodes.¹

Guidelines

The International Parkinson and Movement Disorder Society published an evidence-based review for treatment for motor symptoms of Parkinson's disease (2018).² The review categorically divides treatment recommendations by Parkinson's disease characteristics. Nourianz is noted to be likely efficacious and possibly useful for treatment of motor fluctuations.

References

- 1. Nourianz® tablets [prescribing information]. Bedminster, NJ: Kyowa Kirin; November 2020.
- 2. Fox SH, Katzenschlager R, Lim SY, et al. International Parkinson and movement disorder society evidence-based medicine review: Update on treatments for the motor symptoms of Parkinson's disease. *Mov Disord*. 2018;33(8):1248-1266.

Revision History

Type of Revision	Summary of Changes	Approval Date
Annual	No criteria changes.	09/14/2022
Revision		

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