

Clinical Policy: OnabotulinumtoxinA (Botox)

Reference Number: CP.PHAR.232

Effective Date: 07.01.16

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Line of Business: Commercial, HIM/ICHRA, Medicaid

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

OnabotulinumtoxinA (Botox®) is an acetylcholine release inhibitor and a neuromuscular blocking agent.

FDA Approved Indication(s)

Indication	Adults	Pediatrics	Treatment	Prophylaxis
Overactive bladder	X		X	
Urinary incontinence	X		X	
Migraine	X			X
Upper/lower limb spasticity (includes CP)	X	X	X	
Cervical dystonia (focal dystonia)	X	X	X	
Axillary hyperhidrosis	X		X	
Blepharospasm (focal dystonia)	X	X	X	
Strabismus	X	X	X	
Off-Label Uses				
Laryngeal dystonia*	X		X	
Oromandibular dystonia*	X		X	
Upper extremity dystonia*	X	X	X	
Upper extremity essential tremor*	X		X	
Esophageal achalasia	X		X	
HD and IAS achalasia	X	X	X	
Chronic anal fissure	X		X	
Sialorrhea	X	X	X	

Abbreviations: cerebral palsy (CP); Hirschsprung disease (HD), internal anal sphincter (IAS) achalasia.

*See criteria set entitled Focal Dystonia and Essential Tremor

Botox is indicated for:

- Treatment of:
 - Overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication
 - Urinary incontinence due to detrusor over-activity associated with a neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication
 - Neurogenic detrusor overactivity (NDO) in pediatric patients 5 years of age and older who have an inadequate response to or are intolerant of anticholinergic medication
 - Spasticity in patients 2 years of age and older

- Cervical dystonia (CD) in adult patients, to reduce the severity of abnormal head position and neck pain
- Severe axillary hyperhidrosis that is inadequately managed by topical agents in adult patients
- Blepharospasm associated with dystonia in patients ≥ 12 years of age
- Strabismus in patients ≥ 12 years of age
- Prophylaxis of headaches in adult patients with chronic migraine (≥ 15 days per month with headache lasting 4 hours a day or longer)

Limitation(s) of use:

- Safety and effectiveness of Botox have not been established for:
 - Prophylaxis of episodic migraine (14 headache days or fewer per month)
 - Treatment of hyperhidrosis in body areas other than axillary. Weakness of hand muscles and blepharoptosis may occur in patients who receive Botox for palmar hyperhidrosis and facial hyperhidrosis, respectively. Patients should be evaluated for potential causes of secondary hyperhidrosis (e.g., hyperthyroidism) to avoid symptomatic treatment of hyperhidrosis without the diagnosis and/or treatment of the underlying disease.
 - Treatment of axillary hyperhidrosis in pediatric patients under 18 years of age
- Botox has not been shown to improve upper extremity functional abilities, or range of motion at a joint affected by a fixed contracture.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

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It is the policy of health plans affiliated with Centene Corporation[®] that Botox is **medically necessary** when one of the following criteria is met:

I. Initial Approval Criteria

A. Overactive Bladder and Urinary Incontinence (must meet all):

1. Diagnosis of one of the following (a or b):
 - a. OAB, and member's history is positive for urinary urgency, frequency, and nocturia with or without incontinence;
 - b. Urinary incontinence, and member's history is positive for an associated neurologic condition (e.g., spinal cord injury, spinal dysraphism, multiple sclerosis);
2. Prescribed by or in consultation with a neurologist or urologist;
3. Age \geq 5 years;
4. Member meets one of the following, unless clinically significant adverse effects are experienced or all are contraindicated (a or b, *see Appendix B*):*

* For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395

- a. Adult: failure of one of the following used for at least 30 days (i or ii):
 - i. Anticholinergic agent;
 - ii. Oral beta-3 agonist medication;
 - b. Pediatric: failure of at least two anticholinergic agents, each used for at least 30 days;
5. Botox is not prescribed concurrently with other botulinum toxin products;
 6. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
 7. Treatment plan details number of Units per indication and treatment session;
 8. Request meets one of the following (a or b):
 - a. OAB: Dose does not exceed 100 Units per treatment session;
 - b. Urinary incontinence associated with a neurologic condition:
 - i. Weight \geq 34 kg: does not exceed 200 Units per treatment session;
 - ii. Weight $<$ 34 kg: dose does not exceed 6 units/kg per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member's renewal date, whichever is longer

B. Chronic Migraine (must meet all):

1. Diagnosis of chronic migraine (i.e., \geq 15 headache days per month for at least 3 months with headache lasting 4 hours a day or longer);
2. Prescribed by or in consultation with a neurologist or pain specialist;
3. Age \geq 18 years;

4. Failure of at least 2 of the following oral migraine preventative therapies, each for 8 weeks and from different therapeutic classes, unless clinically significant adverse effects are experienced or all are contraindicated (a, b, or c):*

** For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*

- a. Antiepileptics (e.g., divalproex sodium, sodium valproate, topiramate);
 - b. Beta-blockers (e.g., metoprolol, propranolol, timolol);
 - c. Antidepressants (e.g., amitriptyline, venlafaxine);
5. If currently receiving calcitonin gene-related peptide (CGRP) therapy for migraine prophylaxis and request is for concurrent use of Botox and CGRP therapy (i.e., not switching from one agent to another), both of the following (a and b):*

** For Illinois HIM requests, the step therapy requirements below do not apply as of 1/1/2026 per IL HB 5395*

- a. Member has had a reduction in the overall number of migraine headache days per month with CGRP monotherapy from baseline;
 - b. Provider attestation that despite CGRP monotherapy, member continues to experience a significant number of migraine headache days per month requiring additional therapy for migraine prevention;
6. Botox is not prescribed concurrently with other botulinum toxin products;
 7. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
 8. Treatment plan details number of Units per indication and treatment session;
 9. Dose does not exceed 155 Units per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

C. Upper and Lower Limb Spasticity (includes cerebral palsy) (must meet all):

1. Diagnosis of upper or lower limb spasticity (e.g., associated with paralysis, central nervous system demyelinating diseases such as multiple sclerosis, cerebral palsy, stroke);
2. Prescribed by or in consultation with a neurologist, orthopedist, or physiatrist;
3. Age \geq 2 years;
4. Botox is not prescribed concurrently with other botulinum toxin products;
5. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
6. Treatment plan details number of Units per indication and treatment session;
7. Request meets one of the following (a or b):
 - a. Age \geq 18 years: Upper and/or lower limb: Dose does not exceed 400 Units per treatment session;
 - b. Age 2 through 17 years (i, ii, and iii):
 - i. Upper limb: Dose does not exceed the lower of 6 Units/kg body weight or 200 Units per treatment session;
 - ii. Lower limb: Dose does not exceed the lower of 8 Units/kg body weight or 300 Units per treatment session;

- iii. If upper and lower limb spasticity are treated in the same treatment session, number of Units per treatment session does not exceed the lower of 10 Units/kg body weight or 340 Units per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

D. Cervical Dystonia (*focal dystonia*) (must meet all):

1. Diagnosis of CD;
2. Prescribed by or in consultation with a neurologist, orthopedist, or physiatrist;
3. Age \geq 16 years;
4. Member is experiencing involuntary contractions of the neck and shoulder muscles (e.g., splenius capitis, sternocleidomastoid, levator scapulae, scalene, trapezius, semispinalis capitis) resulting in abnormal postures or movements of the neck, shoulders or head;
5. Contractions are causing pain and functional impairment;
6. Botox is not prescribed concurrently with other botulinum toxin products;
7. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
8. Treatment plan details number of Units per indication and treatment session;
9. Request meets one of the following (a or b):
 - a. Age \geq 18 years: Dose does not exceed 100 Units total in the sternocleidomastoid (SCM) muscle and 300 Units per treatment session;
 - b. Age 16 through 17 years: Dose does not exceed 100 Units total in the SCM muscle and the lower of 10 Units/kg body weight or 300 Units per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

E. Primary Axillary Hyperhidrosis (*excessive underarm sweating*) (must meet all):

1. Diagnosis of primary axillary hyperhidrosis;
2. Prescribed by or in consultation with a neurologist or dermatologist;
3. Age \geq 18 years;
4. Failure of a 6-month trial of topical aluminum chloride, unless contraindicated or clinically significant adverse effects are experienced;
5. Botox is not prescribed concurrently with other botulinum toxin products;
6. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
7. Treatment plan details number of Units per indication and treatment session;
8. Dose does not exceed 100 Units per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

F. Blepharospasm (*focal dystonia - abnormal eyelid muscle contraction*) (must meet all):

1. Diagnosis of blepharospasm;
2. Prescribed by or in consultation with a neurologist or ophthalmologist;
3. Age \geq 12 years;
4. Member is experiencing significant disability in daily functional activities due to interference with vision;
5. Botox is not prescribed concurrently with other botulinum toxin products;
6. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
7. Treatment plan details number of Units per indication and treatment session;
8. Dose does not exceed 2.5 Units per muscle, 7.5 Units per eye, and 15 Units per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member's renewal date, whichever is longer

G. Strabismus (*eye misalignment*) (must meet all):

1. Diagnosis of one of the following (a, b, or c):
 - a. Vertical strabismus (superior and inferior rectus muscles, superior and inferior oblique muscles);
 - b. Horizontal strabismus (medial and lateral rectus muscles) (i or ii):
 - i. Horizontal strabismus $<$ 20 prism diopters;
 - ii. Horizontal strabismus 20 to 50 prism diopters;
 - c. Persistent sixth cranial nerve (VI; abducens nerve) palsy of \geq one month involving the lateral rectus muscle;
2. Prescribed by or in consultation with a neurologist or ophthalmologist;
3. Age \geq 12 years;
4. Botox is not prescribed concurrently with other botulinum toxin products;
5. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
6. Treatment plan details number of Units per indication and treatment session;
7. Request meets one of the following (a, b, or c):
 - a. Vertical strabismus, or horizontal strabismus $<$ 20 prism diopters: Dose does not exceed 2.5 Units per muscle and 5 Units per treatment session;
 - b. Horizontal strabismus 20 to 50 prism diopters: Dose does not exceed 5 Units per muscle and 10 Units per treatment session;
 - c. VI nerve palsy: Dose does not exceed 2.5 Units per treatment session (limited to treatment of one eye).

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member's renewal date, whichever is longer

H. Focal Dystonia and Essential Tremor (off-label) (must meet all):

1. Diagnosis of one of the following (a, b, c, or d):
 - a. Laryngeal dystonia;
 - b. Oromandibular dystonia (OMD);

- c. Upper extremity (UE) dystonia;
 - d. UE essential tremor;
 2. Prescribed by or in consultation with a neurologist, ENT specialist, orthopedist, orofacial pain specialist, or physiatrist;
 3. Age meets one of the following (a or b):
 - a. For UE dystonia: Age \geq 2 years;
 - b. For all other indications: Age \geq 18 years;
 4. For UE dystonia: Failure of a trial of carbidopa/levodopa or trihexyphenidyl (*see Appendix B*), unless clinically significant adverse effects are experienced or both are contraindicated;*
- * For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. Botox is not prescribed concurrently with other botulinum toxin products;
 6. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
 7. Treatment plan details number of Units per indication and treatment session;
 8. Request meets one of the following (a or b):
 - a. Laryngeal dystonia: Dose does not exceed 25 Units per treatment session;
 - b. UE dystonia, UE essential tremor, OMD: Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use and member age (*prescriber must submit supporting evidence; Units per treatment session does not exceed the lower of 10 Units/kg body weight or 340 Units for pediatrics, or 400 Units for adults*).

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

I. Esophageal Achalasia (off-label) (must meet all):

1. Diagnosis of esophageal achalasia;
2. Prescribed by or in consultation with a gastroenterologist;
3. Age \geq 18 years;
4. Member is not a candidate for pneumatic dilation or laparoscopic surgical myotomy (e.g., due to age, comorbidity);
5. Botox is not prescribed concurrently with other botulinum toxin products;
6. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
7. Treatment plan details number of Units per indication and treatment session;
8. Dose does not exceed 100 Units per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

J. Hirschsprung Disease, Internal Anal Sphincter Achalasia (off-label) (must meet all):

1. Diagnosis of one of the following (a or b):
 - a. Hirschsprung disease (HD) and (i or ii):
 - i. Member has an HD subtype known as ultra-short segment HD;

- ii. Botox is prescribed for constipation post-surgery;
 - b. Internal anal sphincter (IAS) achalasia;
 2. Prescribed by or in consultation with a gastroenterologist;
 3. Age \geq 2 years;
 4. Failure of a trial of stool softeners and laxatives (*see Appendix B*), unless clinically adverse effects are experienced or all are contraindicated;*
- * For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
5. Botox is not prescribed concurrently with other botulinum toxin products;
 6. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
 7. Treatment plan details number of Units per indication and treatment session;
 8. Dose does not exceed 100 Units per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

K. Chronic Anal Fissure (off-label) (must meet all):

1. Diagnosis of chronic anal fissure;
2. Prescribed by or in consultation with a gastroenterologist or colorectal surgeon;
3. Age \geq 18 years;
4. Failure of nitroglycerin ointment unless contraindicated or clinically significant adverse effects are experienced;
5. Failure of one of the following (a or b), unless contraindicated or clinically significant adverse effects are experienced (*see Appendix B*);
 - a. Oral/topical nifedipine;
 - b. Oral/topical diltiazem;
6. Botox is not prescribed concurrently with other botulinum toxin products;
7. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
8. Treatment plan details number of Units per indication and treatment session;
9. Dose does not exceed 25 Units per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

L. Chronic Sialorrhea (off-label) (must meet all):

1. Diagnosis of chronic sialorrhea for at least the last three months due to one of the following (a or b):
 - a. Underlying neurologic disorder (e.g., Parkinson disease, atypical parkinsonism, stroke, traumatic brain injury, cerebral palsy, amyotrophic lateral sclerosis);
 - b. Craniofacial abnormality (e.g., Goldenhar syndrome);
2. Prescribed by or in consultation with a neurologist or psychiatrist;
3. Age \geq 21 months;
4. Failure of at least one anticholinergic drug (*see Appendix B*), unless clinically significant adverse effects are experienced or all are contraindicated;*

- * For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395
5. Botox is not prescribed concurrently with other botulinum toxin products;
 6. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
 7. Treatment plan provided detailing number of Units per indication and treatment session;
 8. Dose does not exceed 100 Units per treatment session;

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

M. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

II. Continued Approval

A. Chronic Migraine (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. If receipt of ≥ 2 Botox treatment sessions, member has experienced and maintained a 30% reduction in monthly migraine headache frequency from baseline;
3. Botox is not prescribed concurrently with other botulinum toxin products;
4. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
5. Treatment plan details number of Units per indication and treatment session;
6. If request is for a dose increase, new dose does not exceed 195 Units per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member's renewal date, whichever is longer

B. Esophageal Achalasia (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. Botox is not prescribed concurrently with other botulinum toxin products;
4. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
5. If member has previously received ≥ 2 Botox treatment sessions for esophageal achalasia, it has been at least 24 weeks since the last treatment session;
6. Treatment plan details number of Units per indication and treatment session;
7. If request is for a dose increase, new dose does not exceed 100 Units per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member's renewal date, whichever is longer

C. All Other Indications in Section I (must meet all):

1. Member meets one of the following (a or b):
 - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
 - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. Botox is not prescribed concurrently with other botulinum toxin products;
4. Botulinum toxin therapy for cosmetic or medical conditions has not been administered within the last 12 weeks;
5. Treatment plan details number of Units per indication and treatment session;
6. If request is for a dose increase, request meets one of the following (a - i):
 - a. OAB: Dose does not exceed 100 Units per treatment session;
 - b. Urinary incontinence associated with a neurologic condition: Dose does not exceed 200 Units per treatment session;
 - c. Upper/lower limb spasticity (i or ii):
 - i. Age ≥ 18 years: Upper and/or lower limb: Dose not exceed 400 Units per treatment session;
 - ii. Age 2 through 17 years (a, b, and c):
 - a) Upper limb: Dose does not exceed the lower of 6 Units/kg body weight or 200 Units per treatment session;

- b) Lower limb: Dose does not exceed the lower of 8 Units/kg body weight or 300 Units per treatment session;
- c) If upper and lower limb spasticity are treated in the same treatment session, number of Units per treatment session does not exceed the lower of 10 Units/kg body weight or 340 Units per treatment session;
- d. CD (i or ii):
 - i. Age \geq 18 years: Dose does not exceed 100 Units total in the SCM muscle and 300 Units per treatment session;
 - ii. Age 16 through 17 years: Dose does not exceed 100 Units total in the SCM muscle and the lower of 10 Units/kg body weight or 300 Units per treatment session;
- e. Primary axillary hyperhidrosis: Dose does not exceed 100 Units per treatment session;
- f. Blepharospasm: Dose does not exceed 5 Units per muscle, 15 Units per eye, and 30 Units per treatment session;
- g. Strabismus (i or ii):
 - i. Vertical and horizontal strabismus: Dose does not exceed the lower of a two-fold increase or 25 Units per muscle and 50 Units per treatment session;
 - ii. VI nerve palsy: Dose does not exceed the lower of a two-fold increase or 25 Units per muscle and 25 Units per treatment session;
- h. Focal dystonia and essential tremor (i or ii):
 - i. Laryngeal dystonia: Dose does not exceed 25 Units per treatment session;
 - ii. UE dystonia, UE essential tremor, OMD: Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use and member age (*prescriber must submit supporting evidence; number of Units per treatment session does not exceed the lower of 10 Units/kg body weight or 340 Units for pediatrics, or 400 Units for adults*);
- i. HD, IAS achalasia, chronic anal fissure, sialorrhea: Dose does not exceed 100 Units per treatment session.

Approval duration:

Medicaid/HIM/ICHRA – 12 months

Commercial – 6 months or to member’s renewal date, whichever is longer

D. Other diagnoses/indications (must meet 1 or 2):

- 1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
 - a. For drugs on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace/ICHRA, and CP.PMN.255 for Medicaid; or
 - b. For drugs NOT on the formulary (commercial, health insurance marketplace/ICHRA) or PDL (Medicaid), the non-formulary policy for the

- relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace/ICHRA, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace/ICHRA, and CP.PMN.53 for Medicaid, or evidence of coverage documents;
- B. Cosmetic treatment of hyperfunctional wrinkles of the upper face including glabellar frown lines, deep forehead wrinkles and periorbital wrinkles (crow’s feet);
- C. Episodic migraine (\leq 14 headache days per month): Safety and efficacy have not been established per the package insert;
- D. Total treatment dose per session does not exceed the lower of 10 Units/kg body weight or 340 Units in a 3-month interval for pediatrics and 400 Units for adults.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

CD: cervical dystonia	MS: multiple sclerosis
CGRP: calcitonin gene-related peptide	NDO: neurogenic detrusor overactivity
ER: extended release	OAB: overactive bladder
FDA: Food and Drug Administration	OMD: oromandibular dystonia
HD: Hirschsprung disease	SCI: spinal cord injury
IAS: internal anal sphincter	SCM: sternocleidomastoid
IR: immediate release	UE: upper extremity

Appendix B: Therapeutic Alternatives

This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<i>Overactive bladder, urinary incontinence</i>		
oxybutynin (Ditropan [®] /XL, Gelnique [®]) (anticholinergic agent)	<ul style="list-style-type: none"> • Immediate-release (IR) tablets (adults and children): 5 mg PO two to three times daily • Extended-release (ER) tablets: 5-10 mg PO QD • Topical gel: Apply contents of one sachet topically QD 	<ul style="list-style-type: none"> • IR: 20 mg/day • ER: 30 mg/day • Gel: one sachet/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
tolterodine tartrate (Detrol [®] /LA) (anticholinergic agent)	<ul style="list-style-type: none"> • Immediate-release tablets: 2 mg PO BID • Extended-release tablets: 4 mg PO QD 	4 mg/day
fesoterodine (Toviaz [®]) (anticholinergic agent)	<ul style="list-style-type: none"> • Pediatrics: 4 mg PO QD. If needed, dosage may be increased to 8 mg PO QD • Adults: 4 mg PO QD 	8 mg/day
solifenacin (Vesicare [®]) (anticholinergic agent)	<ul style="list-style-type: none"> • Adults and children weighing more than 60 kg: 5 mg PO QD • Children weighing between 46 to 60 kg: 4 mg PO QD • Children weighing between 16 to 45 kg: 3 mg PO QD • Children weighing between 9 to 15 kg: 2 mg QD 	10 mg/day
darifenacin (anticholinergic agent)	7.5 mg PO QD	15 mg/day
tropium (Sanctura [®] , Sanctura [®] XR) (anticholinergic agent)	<ul style="list-style-type: none"> • IR: 20 mg PO BID • ER: 60 mg PO QD 	60 mg/day
Myrbetriq [®] (mirabegron) (beta-3 agonist)	25 mg PO QD	50 mg/day
Gemtesa [®] (vibegron) (beta-3 agonist)	75 mg PO QD	75 mg/day
Chronic migraine		
<p><i>Examples of oral migraine preventive therapies -</i></p> <ul style="list-style-type: none"> • Anticonvulsants: divalproex (Depakote[®]), topiramate (Topamax[®]) • Beta blockers: propranolol (Inderal[®]), metoprolol (Lopressor[®]), timolol • Antidepressants/tricyclic antidepressants: amitriptyline (Elavil[®]), venlafaxine (Effexor[®]) 	Refer to prescribing information for dosing regimens.	Refer to prescribing information
Primary axillary hyperhidrosis		
Drysol [®] (aluminum chloride)	Apply topically once daily	One application/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<i>Dystonia</i>		
carbidopa/levodopa (Sinemet [®] , Duopa [®] , Rytary [®])	25 mg/100 mg PO QD, and increase by 1 tablet every 3 to 5 days.	1,200 mg/day of levodopa
trihexyphenidyl	30 mg PO QD	30 mg/day
<i>HD, IAS achalasia</i>		
Dulcolax [®] (bisacodyl)	5 to 15 mg PO or 10 mg PR QD	30 mg/day
MiraLax [®] (Polyethylene glycol 3350)	17 grams of polyethylene glycol 3350 in 4-8 oz water by mouth once daily	17 grams/day
Colace [®] (Docusate sodium)	50-200 mg PO QD-QID	200 mg/day
<i>Chronic anal fissure</i>		
nitroglycerin 0.2% ointment (Rectiv [®])	15 to 30 mg (2.5 to 5 cm as squeezed from the tube, about 1 to 2 inches), applied topically to skin every 8 hours while awake and at bedtime; application frequency may be increased to every 6 hours if needed; alternatively, a regimen providing a 12-hour nitrate-free interval may be used; apply dosage once each morning, then 6 hours later	75 mg (12.5 cm as squeezed from the tube)/day
nifedipine or diltiazem (oral or topical ointment/gel-compounded)	PO: At provider discretion Intra-anal: 0.2% ointment or gel, applied around fissure(s) 2 times daily for 6-8 weeks	Varies
<i>Sialorrhea: examples of anticholinergic drugs</i>		
glycopyrrolate (Glycate [®] oral tablets, Cuvposa [®] oral solution)	<ul style="list-style-type: none"> Adults: 1 mg PO TID (Off-label: Lakraj 2013) Pediatrics: chronic drooling: children \geq 3 years and adolescents \leq 16 years: oral solution (Cuvposa): 20 mcg/kg/dose 3 times daily, titrate in increments of 20 mcg/kg/dose every 5 to 7 days as tolerated to response up to a maximum dose of 100 mcg/kg/dose 3 times daily; not to exceed 1,500 to 3,000 mcg/dose. (FDA labeled) 	See regimen information
benztropine mesylate (oral tablets - 0.5 mg, 1 mg, 2 mg)	Mean doses of 3.8 mg/day have been used in adults and pediatrics \geq 4 years. Benztropine typically is administered in divided doses titrating up as needed.	See regimen information

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	(Off-label - Sridharan 2018, Lakraj 2013; Micromedex, package insert)	

Therapeutic alternatives are listed as Brand name[®] (generic) when the drug is available by brand name only and generic (Brand name[®]) when the drug is available by both brand and generic.

Appendix C: Contraindications and Boxed Warnings

- Contraindication(s):
 - Hypersensitivity to any botulinum toxin preparation or to any of the components in the formulation
 - Infection at the proposed injection site
 - Intradetrusor injections: urinary tract infection or urinary retention
- Boxed warning(s): distant spread of toxin effect

Appendix D: Botulinum Toxin Product Interchangeability

- Potency Units of Botox are not interchangeable with other botulinum toxin product preparations (e.g., Dysport[®], Myobloc[®], Xeomin[®]).

Appendix E: Guideline Support for Botulinum Toxin Use

Indication	Guideline
<i>Focal Dystonia* and Essential Tremor, and Headache</i>	
Blepharospasm, cervical dystonia, adult spasticity, and headache	Academy of Neurology (2016)
Migraine prevention	American Academy of Neurology and the American Headache Society (Neurology 2012, Headache 2021)
Laryngeal dystonia	American Academy of Otolaryngology-Head and Neck Surgery Foundation (AAO-HNS, 2018)
Oromandibular dystonia	American Academy of Oral Medicine (2018)
Focal limb dystonia - UE**	American Academy of Neurology (2008)
Essential tremor - UE	American Academy of Neurology (2008, 2011)
Sialorrhea	American Academy of Cerebral Palsy and Developmental Medicine (AACPD, 2018); International Parkinson and Movement Disorder Society (2018)
OAB/urinary incontinence	American Urological Association Society of Urodynamics (2019)
<i>Gastrointestinal Conditions (see guidelines for required oral medication information)</i>	
Esophageal achalasia	American College of Gastroenterology (2020)
HD and IAS achalasia	American Pediatric Surgical Association (2017)
Chronic anal fissure	American College of Gastroenterology (2021)

*American Academy of Neurology (AAN) classifies Botox use for hemifacial spasm and motor tics as category C, and notes that data are inadequate to make a recommendation for lower limb dystonia. All other AAN Botox recommendations above are classified as category B - probably effective.

**Policy criteria requiring failure of oral medication for dystonias are limited to dystonias affecting the limbs (see Cloud and Jinnah, 2010).

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose																																																
Adults: OAB	Up to 5 Units IM per injection across up to 20 injection sites in the detrusor muscle for a total of up to 100 Units per treatment session	See dosing regimens for maximum dose																																																
Pediatric NDO	<ul style="list-style-type: none"> • Weight \geq 34 kg: 200 units • Weight $<$ 34 kg: 6 units/kg (see table below) 	Frequency: <ul style="list-style-type: none"> • Esophageal achalasia: one treatment session every 24 weeks. • All other indications: one treatment session every 12 weeks. 																																																
	<table border="1"> <thead> <tr> <th>Body weight (kg)</th> <th>Botox (mL)</th> <th>Diluent (mL)</th> <th>Final dose of Botox in dosing syringe</th> </tr> </thead> <tbody> <tr> <td>12 to $>$ 14 kg</td> <td>3.6</td> <td>6.4</td> <td>72 units</td> </tr> <tr> <td>14 to $<$ 16 kg</td> <td>4.2</td> <td>5.8</td> <td>84 units</td> </tr> <tr> <td>16 to $<$ 18 kg</td> <td>4.8</td> <td>5.2</td> <td>96 units</td> </tr> <tr> <td>18 to $<$ 20 kg</td> <td>5.4</td> <td>4.6</td> <td>108 units</td> </tr> <tr> <td>20 to $<$ 22 kg</td> <td>6</td> <td>4</td> <td>120 units</td> </tr> <tr> <td>22 to $<$ 24 kg</td> <td>6.6</td> <td>3.4</td> <td>132 units</td> </tr> <tr> <td>24 to $<$ 26 kg</td> <td>7.2</td> <td>2.8</td> <td>144 units</td> </tr> <tr> <td>26 to $<$ 28 kg</td> <td>7.8</td> <td>2.2</td> <td>156 units</td> </tr> <tr> <td>28 to $<$ 30 kg</td> <td>8.4</td> <td>1.6</td> <td>168 units</td> </tr> <tr> <td>30 to $<$ 32 kg</td> <td>9</td> <td>1</td> <td>180 units</td> </tr> <tr> <td>32 to $<$ 34 kg</td> <td>9.6</td> <td>0.4</td> <td>192 units</td> </tr> </tbody> </table>		Body weight (kg)	Botox (mL)	Diluent (mL)	Final dose of Botox in dosing syringe	12 to $>$ 14 kg	3.6	6.4	72 units	14 to $<$ 16 kg	4.2	5.8	84 units	16 to $<$ 18 kg	4.8	5.2	96 units	18 to $<$ 20 kg	5.4	4.6	108 units	20 to $<$ 22 kg	6	4	120 units	22 to $<$ 24 kg	6.6	3.4	132 units	24 to $<$ 26 kg	7.2	2.8	144 units	26 to $<$ 28 kg	7.8	2.2	156 units	28 to $<$ 30 kg	8.4	1.6	168 units	30 to $<$ 32 kg	9	1	180 units	32 to $<$ 34 kg	9.6	0.4	192 units
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Adults: urinary incontinence associated with neurologic condition	Up to approximately 6.7 Units IM per injection across up to 30 injection sites in the detrusor muscle for a total of up to 200 Units per treatment session																																																	
Adults: chronic migraine	Up to 5 Units IM per injection across up to 7 head/neck muscles for a total of 155 - 195 Units per treatment session.																																																	
Adults: upper and lower limb spasticity	Up to 50 Units IM per injection and up to 400 Units per treatment session																																																	
Pediatrics: upper and limb spasticity	<ul style="list-style-type: none"> • Upper limb spasticity: Up to the lower of 6 Units/kg or 200 Units IM per treatment session • Lower limb spasticity: Up to the lower of 8 Units/kg or 300 Units IM per treatment session • Upper and lower limb spasticity: Up to the lower of 10 Units/kg or 340 Units IM per treatment session 																																																	
Adults: CD	Up to 50 Units IM per injection, 100 Units total in the sternocleidomastoid (SCM) muscle, and 300 Units per treatment session																																																	
Pediatrics: CD	Up to 50 Units IM per injection, 100 Units total in the SCM muscle, and the lower of 10 Units/kg body weight or 300 Units per treatment session																																																	

Indication	Dosing Regimen	Maximum Dose
Adults: axillary hyperhidrosis	Up to 50 Units IM per axilla per treatment session	
Adults and pediatrics: blepharospasm	<ul style="list-style-type: none"> • Botox naive: Up to 2.5 Units IM per muscle, 7.5 Units per eye, and 15 Units per treatment session • Botox experienced: Up to 5 Units IM per muscle, 15 Units per eye, and 30 Units per treatment session 	
Adults and pediatrics: strabismus	<ul style="list-style-type: none"> • Botox naive: <ul style="list-style-type: none"> ○ Vertical muscles, or horizontal strabismus < 20 prism diopters: Up to 2.5 Units IM per muscle and 5 Units per treatment session ○ Horizontal strabismus 20 to 50 prism diopters: Up to 5 Units IM per muscle and 10 Units per treatment session ○ VI nerve palsy: 2.5 Units IM in the medial rectus muscle and 2.5 Units per treatment session • Botox experienced: <ul style="list-style-type: none"> ○ Vertical and horizontal strabismus: Up to the lower of a two-fold increase or 25 Units IM per muscle and 50 Units per treatment session ○ VI nerve palsy: Up to the lower of a two-fold increase or 25 Units IM per muscle and 25 Units per treatment session 	
<i>Off-label uses</i>		
Laryngeal dystonia	Up to 25 Units IM per treatment session. <i>(Off-label - Micromedex 2020)</i>	
UE dystonia, UE essential tremor, OMD	Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use and member age (prescriber must submit supporting evidence; number of Units per treatment session does not exceed the lower of 10 Units/kg body weight or 340 Units IM for pediatrics, or 400 Units IM for adults).	
Esophageal achalasia	Up to 100 Units IM per treatment session. <i>(Off-label - Vaezi 2013)</i>	
HD, IAS achalasia	Up to 100 Units IM per treatment session. <i>(Off-label - Langer 2017)</i>	
Chronic anal fissure	Up to 100 Units IM per treatment session. <i>(Off-label – ACG Guidelines 2021)</i>	
Chronic sialorrhea	Up to 100 Units IM per treatment session. <i>(Off-label – Lagalla 2006)</i>	

VI. Product Availability

Vials: 100 Units, 200 Units

VII. References

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Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J0585	Injection, onabotulinumtoxinA, 1 unit

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2022 annual review: no significant changes; WCG.CP.PHAR.232 policy retired per SDC recommendation; removal of required 2 week trial duration of nitroglycerin and nifedipine/diltiazem for chronic anal fissures; adjusted Xeomin blepharospasm dose in Appendix B from 25 units to 50 units per PI; removal of the statement “*The treatment of hyperhidrosis is a benefit exclusion for HIM;” references reviewed and updated.	02.07.22	05.22
Spelling corrected for “medial” for strabismus in section I and V.	05.05.22	
Added criteria for concurrent use with CGRP therapy requiring supportive evidence from published studies or clinical practice guidelines, positive response with CGRP monotherapy, and continued migraine burden. Template changes applied to other diagnoses/indications and continued therapy section.	07.19.22	11.22
Ad Hoc update: max dose for chronic anal fissures updated from 25 units to 100 units per treatment session per ACG guidelines; updated limitation of use for hyperhidrosis per PI.	01.18.23	
2Q 2023 annual review: for chronic anal fissure, revised maximum dosing allowance up to 25 units for initial therapy and 100 units for continued therapy per treatment session; added chronic sialorrhea off-label indication; references reviewed and updated. Per February SDC: removed Dysport and/or Xeomin redirection requirement for upper and lower limb spasticity, cervical dystonia, blepharospasm, overactive bladder, chronic migraine, and axillary hyperhidrosis; for Overactive Bladder, updated criteria for adults to require use of two anticholinergic agents or one oral beta-3 agonist medication (previously both were required); changed Medicaid and HIM approval durations to 12 months.	02.21.23	05.23
Revised max dose for OMD from “25 units” to standard language “Dose is supported by practice guidelines or peer-reviewed literature for the relevant off-label use and member age (prescriber must submit	08.25.23	11.23

Reviews, Revisions, and Approvals	Date	P&T Approval Date
supporting evidence; Units per treatment session does not exceed the lower of 10 Units/kg body weight or 340 Units for pediatrics, or 400 Units for adults).”		
2Q 2024 annual review: for chronic sialorrhea changed age from ≥ 18 years to ≥ 21 months; references reviewed and updated.	01.18.24	05.24
Per SDC, for OAB, revised criteria for adults to require use of one anticholinergic agent (previously two anticholinergics were required).	05.15.24	06.24
For chronic migraine continuation therapy requests, modified maximum dosing to allow up to 195 units per treatment session.	10.01.24	
2Q 2025 annual review: for focal dystonia and essential tremor, added prescriber option for orofacial pain specialist; updated Appendix B with additional agents for OAB; references reviewed and updated.	01.16.25	05.25
Added step therapy bypass for IL HIM per IL HB 5395.	06.27.25	
Per December SDC for chronic migraine removed requirement for evidence from two high quality published studies to support concurrent use of Botox and CGRP therapy.	12.04.25	02.26
2Q 2026 annual review: for primary axillary hyperhidrosis, removed step therapy bypass for IL HIM disclaimer for class alignment; references reviewed and updated. Per March SDC for chronic migraine, simplified criteria for concurrent use with CGRP to member has had a reduction in the overall migraine headache days per month with CGRP monotherapy and provider attestation of a significant number of migraine headache days despite CGRP monotherapy. Added ICHRA line of business.	04.24.26	05.26

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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