



Medical Policy Manual **Draft Revised Policy: Do Not Implement**

DaxibotulinumtoxinA-ianm (Daxxify™)

IMPORTANT REMINDER

We develop Medical Policies to provide guidance to Members and Providers. This Medical Policy relates only to the services or supplies described in it. The existence of a Medical Policy is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the Medical Policy. For a determination of the benefits that a Member is entitled to receive under his or her health plan, the Member's health plan must be reviewed. If there is a conflict between the medical policy and a health plan or government program (e.g., TennCare), the express terms of the health plan or government program will govern.

**The proposal is to add text/statements in red and to delete text/statements with strikethrough:
POLICY**

INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indication

- The treatment of cervical dystonia in adult patients.

All other indications are considered experimental/investigational and not medically necessary.

~~PRESCRIBER SPECIALTIES~~

~~The medication must be prescribed by, or in consultation with~~ **a provider specialized in treating the member's condition.** ~~one of the following:~~

~~A. Cervical dystonia: neurologist, orthopedist or physiatrist~~

EXCLUSIONS

Coverage will not be provided for cosmetic use.

CRITERIA FOR INITIAL APPROVAL

Cervical dystonia

Authorization of 12 months may be granted for the treatment of adults with cervical dystonia (e.g., torticollis) when both of the following are met:

- Member is 18 years of age or older
- There is abnormal placement of the head with limited range of motion in the neck

CONTINUATION OF THERAPY

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria and be experiencing benefit from therapy.

APPLICABLE TENNESSEE STATE MANDATE REQUIREMENTS



BlueCross BlueShield
of Tennessee

Policy

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BlueCross BlueShield of Tennessee's Medical Policy complies with Tennessee Code Annotated Section 56-7-2352 regarding coverage of off-label indications of Food and Drug Administration (FDA) approved drugs when the off-label use is recognized in one of the statutorily recognized standard reference compendia or in the published peer-reviewed medical literature.

ADDITIONAL INFORMATION

For appropriate chemotherapy regimens, dosage information, contraindications, precautions, warnings, and monitoring information, please refer to one of the standard reference compendia (e.g., the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) published by the National Comprehensive Cancer Network®, Drugdex Evaluations of Micromedex Solutions at Truven Health, or The American Hospital Formulary Service Drug Information).

REFERENCES

1. Daxxify [package insert]. Newark, CA: Revance Therapeutics, Inc; **November** 2023.

EFFECTIVE DATE

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