Pharmacy Medical Necessity Guidelines
Tasmar® (Tolcapone)

Effective: 1/1/15

<table>
<thead>
<tr>
<th>Clinical Documentation and Prior Authorization Required</th>
<th>√ Type of Review – Case Management</th>
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<tbody>
<tr>
<td>Not Covered</td>
<td>Type of Review – Clinical Review</td>
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<td>Fax: 617-673-0956</td>
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<td>Pharmacy (RX) or Medical (MED) Benefit</td>
<td>RX Department to Review</td>
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OVERVIEW

FDA-APPROVED INDICATIONS

PHARMACY COVERAGE GUIDELINES

Tufts Health Plan – Network Health may authorize coverage of Tasmar® (tolcapone) for members when all of the following criteria for a particular regimen are met and limitations do not apply:

• The member is diagnosed with Parkinson’s disease
• The member will be taking tolcapone concurrently with levodopa/carbidopa
• The member tried and failed therapy with the preferred catechol-o-methyltransferase (COMT) inhibitor agent, entacapone

Upon renewal,
• The member has had an office visit and has been re-assessed for this condition within the past year, and continued therapy with this medication is considered medically necessary.

LIMITATIONS

Approval duration is limited to one year.
The quantity is limited to six tablets per day.

CODES

None

REFERENCES


APPROVAL HISTORY

• 11/04/2014: Reviewed by the Pharmacy and Therapeutics Committee.

BACKGROUND, PRODUCT, AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for Tufts Health Plan – Network Health benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with the applicable Member Handbook and in coordination with the member’s physician(s). 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 Tufts Health Plan – Network Health service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan – Network Health reviews Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medical Necessity Guidelines apply to all fully insured Tufts Health Plan – Network Health offerings unless otherwise noted in this policy or the applicable Member Handbook. Check the applicable product formulary in the Pharmacy section of our website to determine if the drug requires you to get prior authorization.
For Tufts Health Unify (Medicare-Medicaid One Care for people ages 21 – 64), please refer to Tufts Health Unify Prior Authorization Medical Necessity Guidelines.

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.