



Drug Coverage Policy

Effective Date4/15/2024

Coverage Policy Number.....IP0392

Tizanidine

- tizanidine 2 mg, 4 mg and 6 mg capsules

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. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment and have discretion in making individual coverage determinations. 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.

Medical Necessity Criteria

Coverage criteria is listed for product in below table:

Employer Plans:

Product	Criteria
Tizanidine 2 mg, 4 mg and 6 mg capsules	Tizanidine capsules is considered medically necessary when there is documentation of failure, contraindication, or intolerance to ONE of the following: <ol style="list-style-type: none"> 1. tizanidine 1 mg tablet 2. tizanidine 2 mg tablet

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

Reauthorization Criteria

Continuation of tizanidine capsules is considered medically necessary when the above medical necessity criteria are met AND there is documentation of beneficial response.

Authorization Duration

Initial approval duration: up to 12 months
Reauthorization approval duration: up to 12 months

Conditions Not Covered

Any other use is considered experimental, investigational, or unproven.

Background

OVERVIEW

Tizanidine hydrochloride is a central alpha-2-adrenergic agonist indicated for the management of spasticity¹. Because of the short duration of therapeutic effect, treatment with tizanidine hydrochloride capsules should be reserved for those daily activities and times when relief of spasticity is most important.

References

1. Advagen Pharma Ltd. Tizanidine capsules [product information]. Plainsboro, NJ: Advagen Pharma Ltd. November 2019.

Revision Details

Type of Revision	Summary of Changes	Date
Annual Revision	No criteria changes	4/15/2024

The policy effective date is in force until updated or retired.

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