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Coverage Policy Number **IP0470**

Collagenase for Individual and Family Plans

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Related Coverage Resources

Quantity Limitations

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.

Overview

This policy supports medical necessity review for topical collagenase ointment (Santyl®) for Individual and Family Plans.

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

Medical Necessity Criteria

Collagenase is considered medically necessary when the following are met:

1. **Debridement of Chronic Dermal Ulcers and Severely Burned Areas.** Individual meets the following criteria (A):
    A. Individual is being treated for debridement of chronic dermal ulcers and severely burned areas.

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.

Reauthorization Criteria

Collagenase (Santyl) is considered medically necessary for continued use when initial 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
Collagenase Santyl Ointment is a sterile enzymatic debriding ointment which contains 250 collagenase units per gram of white petrolatum USP. It is indicated for debriding chronic dermal ulcers and severely burned areas. Collagenase Santyl Ointment should be applied once daily or more frequently if the dressing becomes soiled, as from incontinence. For example, according to the manufacturer, a 3 x 3 inch (8 x 8 cm) wound will require approximately 180 grams of Collagenase Santyl ointment if applied once daily for 30 days[2].

References

1. Collagenase Santyl® ointment [prescribing information]. Forth Worth, TX: Smith & Nephew, Inc., May 2019.
2. Santyl Dosing Calculator. Available online at: https://www.santyl.com/hcp/dosing.