Pharmacy Medical Necessity Guidelines:
Neupro® (rotigotine)

Effective: March 10, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RXUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

FDA-APPROVED INDICATIONS

Neupro® (rotigotine transdermal system) is a dopamine agonist indicated for the treatment of Parkinson's disease and for the treatment of moderate-to-severe primary Restless Legs Syndrome.

COVERAGE GUIDELINES

The plan may authorize coverage of **Neupro® (rotigotine)** for Members when **ALL** of the following criteria for a particular regimen are met and limitations do not apply:

1. The Member has one of the following diagnoses:
   a. Parkinson's disease
   b. Restless leg syndrome (RLS)

AND

2. The Member has had an inadequate response with or adverse reaction to two oral dopamine agonist agents, ropinirole and pramipexole, or the provider indicates therapy with the oral agents is clinically inappropriate

LIMITATIONS

None

CODES

None

REFERENCES

1. Neupro (rotigotine transdermal system) [prescribing information]. Smyrna, GA: UCB, Inc; July 2021.
2. Liang TW Medical management of motor fluctuations and dyskinesia in Parkinson disease. Available at: www.uptodate.com. Accessed: 27 February 2024.
3. Silber MH. Treatment of restless leg syndrome and periodic limb movement disorder in adults. Available at: www.uptodate.com. Accessed: 27 February 2024.
4. Spindler MA. Initial pharmacological management of Parkinson disease. Available at: www.uptodate.com. Accessed 27 February 2024.

APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. June 13, 2023: No changes.
2. March 12, 2024: Effective June 1, 2024, updated previous trial language. Updated fax number for RxUM.
3. March 11, 2025: No changes
4. March 10, 2026: No changes.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. 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 service area who are

medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

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.

Provider Services