

## Clinical Policy: Istradefylline (Nourianz)

Reference Number: CP.PMN.217

Effective Date: 03.01.20

Last Review Date: 02.26

Line of Business: Commercial, HIM, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### Description

Istradefylline (Nourianz<sup>®</sup>) is an adenosine A<sub>2A</sub> receptor antagonist.

### FDA Approved Indication(s)

Nourianz is indicated as adjunctive treatment to levodopa/carbidopa in adult patients with Parkinson's disease (PD) experiencing "off" episodes.

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Nourianz is **medically necessary** when the following criteria are met:

#### I. Initial Approval Criteria

##### A. Parkinson's Disease (must meet all):

1. Diagnosis of PD;
2. Age  $\geq$  18 years;
3. Member is experiencing "off" time (*see Appendix D*) on levodopa/carbidopa therapy;
4. Failure of two of the following adjunct drugs prescribed in combination with levodopa/carbidopa, each from different classes, unless clinically significant adverse effects are experienced or all are contraindicated:\*<sup>^</sup>
  - a. MAO-B inhibitor: rasagiline;
  - b. COMT inhibitor: entacapone (Comtan<sup>®</sup>/Stalevo<sup>®</sup>), tolcapone;
  - c. Dopamine agonist: ropinirole/ropinirole ER, pramipexole/pramipexole ER;

*\*Prior authorization may be required for the above agents*  
*<sup>^</sup>For Illinois HIM requests, the step therapy requirements above do not apply as of 1/1/2026 per IL HB 5395*
5. Prescribed in combination with levodopa/carbidopa;
6. Dose does not exceed both of the following (a and b):
  - a. 40 mg per day;
  - b. 1 tablet per day.

**Approval duration: 12 months**

##### B. Other diagnoses/indications (must meet 1 or 2):

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):

- a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

## **II. Continued Therapy**

### **A. Parkinson's Disease (must meet all):**

1. Member meets one of the following (a or b):
  - a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
  - b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B*);
2. Member is responding positively to therapy;
3. Prescribed in combination with levodopa/carbidopa;
4. If request is for a dose increase, new dose does not exceed both of the following (a and b):
  - a. 40 mg per day;
  - b. 1 tablet per day.

**Approval duration: 12 months**

### **B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line

of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

COMT: catechol-O-methyl transferase

FDA: Food and Drug Administration

MAO-B: monoamine oxidase type B

PD: Parkinson’s disease

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
<b>COMT Inhibitors</b>		
carbidopa/levodopa/ entacapone	PO: Dose should be individualized based on therapeutic response; doses may be adjusted by changing strength or adjusting interval. Fractionated doses are not recommended and only 1 tablet should be given at each dosing interval.	1,200 mg of levodopa/day
entacapone	PO: 200 mg with each dose of levodopa/carbidopa	1,600 mg/day
tolcapone (Tasmar <sup>®</sup> )	PO: 100 mg 3 times daily, as adjunct to levodopa/carbidopa	300 mg/day
<b>MAO-B Inhibitors</b>		
rasagiline (Azilect <sup>®</sup> )	PO: Monotherapy or adjunctive therapy (not including levodopa): 1 mg once daily. Adjunctive therapy with levodopa: Initial: 0.5 mg once daily; may increase to 1 mg once daily based on response and tolerability.	1 mg/day
<b>Dopamine Agonists</b>		
pramipexole (Mirapex <sup>®</sup> )	PO: Initial dose: 0.125 mg 3 times daily, increase gradually every 5 to 7 days; maintenance (usual): 0.5 to 1.5 mg 3 times daily	4.5 mg/day
pramipexole ER (Mirapex <sup>®</sup> ER)	PO: Initial dose: 0.375 mg once daily; increase gradually not more frequently than every 5 to 7 days to 0.75 mg once daily and then, if necessary, by 0.75 mg per dose	4.5 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
ropinirole	PO: Recommended starting dose: 0.25 mg 3 times/day. Based on individual patient response, the dosage should be titrated with weekly increments: Week 1: 0.25 mg 3 times/day; total daily dose: 0.75 mg; week 2: 0.5 mg 3 times/day; total daily dose: 1.5 mg; week 3: 0.75 mg 3 times/day; total daily dose: 2.25 mg; week 4: 1 mg 3 times/day; total daily dose: 3 mg. After week 4, if necessary, daily dosage may be increased by 1.5 mg/day on a weekly basis up to a dose of 9 mg/day, and then by up to 3 mg/day weekly to a total of 24 mg/day.	24 mg/day
ropinirole ER	PO: Initial dose: 2 mg once daily for 1 to 2 weeks, followed by increases of 2 mg/day at weekly or longer intervals based on therapeutic response and tolerability	24 mg/day

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*

*Appendix C: Contraindication/Boxed Warnings*

None reported

*Appendix D: General Information*

- Off time/episodes represent a return of PD symptoms (bradykinesia, rest tremor, or rigidity) when the L-dopa treatment effect wears off after each dosing interval.
- PD symptoms, resulting from too little levodopa (L-dopa), are in contrast with dyskinesia which typically results from too much L-dopa. The alterations between “on” time (the time when PD symptoms are successfully suppressed by L-dopa) and “off” time is known as “motor fluctuations”.
- The addition of carbidopa to L-dopa prevents conversion of L-dopa to dopamine in the systemic circulation and liver.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Adjunctive treatment to levodopa/carbidopa in adult patients with PD experiencing “off” episodes	20 mg PO QD	40 mg/day

**VI. Product Availability**

Tablets: 20 mg, 40 mg

**VII. References**

1. Nourianz Prescribing Information. Bedminster, NJ: Kyowa Kirin, Inc.; March 2023. Available at: <https://www.nourianzhcp.com/>. Accessed October 21, 2025.

2. de Bie RMA, Katzenschlager R, Swinnen BEKS, et al. Update on treatments for Parkinson's disease motor fluctuations - an International Parkinson and Movement Disorder Society evidence-based medicine review. *Mov Disord.* 2025;40(5):776-794.
3. Pringsheim T, Day GS, Smith DB, et al. Dopaminergic therapy for motor symptoms in early Parkinson disease practice guideline summary: A report of the AAN guideline subcommittee. *Neurology* November 2021;97(2):942-957.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2022 annual review: no significant changes; changed continued therapy commercial approval duration from length of benefit to 12 months or duration of request, whichever is less; references reviewed and updated.	10.21.21	02.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.05.22	
1Q 2023 annual review: no significant changes; references reviewed and updated.	11.14.22	02.23
1Q 2024 annual review: no significant changes; references reviewed and updated.	10.13.23	02.24
1Q 2025 annual review: no significant changes; references reviewed and updated.	11.13.24	02.25
1Q 2026 annual review: added step therapy bypass for IL HIM per IL HB 5395; revised initial approval duration and continued approval duration for all lines of business to 12 months; for continued therapy, aligned initial therapy requirement for concurrent treatment with carbidopa/levodopa; references reviewed and updated.	10.21.25	02.26

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of

insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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