Acute tocolytic therapy with calcium channel blockers, magnesium sulfate, prostaglandin inhibitors, and parenteral terbutaline may be considered medically necessary for the induction of tocolysis in patients with preterm (<37 weeks’ gestational age) labor.

Maintenance (beyond 48-72 hours) tocolytic therapy with any medication is considered investigational, as there is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

**NOTE:** Terbutaline should only be administered in a hospital setting and is not to be administered in an outpatient or home setting. Oral terbutaline is contraindicated for the treatment or prevention of preterm labor.

**Policy Guidelines**

Patient selection criteria for induction of tocolysis include regular uterine contractions associated with cervical changes. Induction of tocolysis typically requires hospitalization to monitor for incipient delivery.

**Cross-reference:**
MP-7.025 Progesterone Therapy as a Technique to Reduce Preterm Delivery in High Risk Pregnancies

II. **PRODUCT VARIATIONS**

This policy is applicable to all programs and products administered by Capital BlueCross unless otherwise indicated below.

FEP PPO*
**MEDICAL POLICY**

<table>
<thead>
<tr>
<th>POLICY TITLE</th>
<th>ACUTE AND MAINTENANCE TOCOLYSIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICY NUMBER</td>
<td>MP-7.022</td>
</tr>
</tbody>
</table>

*Refer to FEP Medical Policy Manual MP-5.30.06, Tocolytics. The FEP Medical Policy Manual can be found at: [www.fepblue.org](http://www.fepblue.org).*

### III. DESCRIPTION/BACKGROUND

Tocolysis refers to the suppression of preterm labor to delay delivery. A variety of medications are proposed as tocolytic agents; none of the currently available options are approved by the U.S. Food and Drug Administration (FDA) for this indication. The same medications could also be used as maintenance therapy following successful tocolysis.

General indications for tocolysis, or the suppression of preterm labor, include continued regular uterine contractions associated with cervical changes in a pregnant woman at less than 37 weeks’ gestation. Successful delay of preterm delivery allows further fetal development and precludes the complications of preterm delivery, especially neonatal respiratory distress syndrome. Even short-term delay of delivery is thought to be beneficial in that it allows treatment of the patient with corticosteroids, which has proved beneficial in ameliorating the effects of neonatal respiratory distress syndrome (RDS). In some cases, a short delay in delivery may also allow transport of the pregnant woman to a medical center better equipped to handle premature delivery and neonatal intensive care.

A variety of agents have been used for tocolysis. The only FDA-approved tocolytic drug is ritodrine, a beta-sympathomimetic. Ritodrine is no longer available in the United States and thus only off-label medications are available. Terbutaline sulfate, also a beta-sympathomimetic, is an alternative to ritodrine, for acute and maintenance tocolysis. Terbutaline is available as an oral or intravenous medication and, more recently, terbutaline has been administered by continuous subcutaneous infusion via a portable pump for maintenance tocolysis. Other tocolytic drugs include calcium channel blockers (e.g., nifedipine), magnesium sulfate, oxytocin receptor antagonists (e.g., atosiban), prostaglandin inhibitors (e.g., indomethacin) and nitrates (e.g., nitroglycerin).

Tocolytic agents have potential risks as well as potential benefits. A 2012 guideline issued by the American College of Obstetricians and Gynecologists (ACOG) summarized the potential adverse effects of common classes of tocolytic agents:

**Calcium Channel Blockers**

- Maternal side effects: Dizziness, flushing, and hypotension; suppression of heart rate, contractility, and left ventricular systolic pressure when used with magnesium sulfate; and elevation of hepatic transaminases
- Fetal or newborn adverse effects: No known adverse effects
Non-steroidal Anti-inflammatory Drugs (NSAIDs)

- Maternal side effects: Nausea, esophageal reflux, gastritis, and emesis; platelet dysfunction is rarely of clinical significance in patients without underlying bleeding disorder
- Fetal or newborn adverse effects: In utero constriction of ductus arteriosus*, oligohydramnios*, necrotizing enterocolitis in preterm newborns, and patent ductus arteriosus in newborn†

*Greatest risk associated with use for longer than 48 hours
†Data are conflicting regarding this association

Beta-adrenergic Receptor Agonists

- Maternal side effects: Tachycardia, hypotension, tremor, palpitations, shortness of breath, chest discomfort, pulmonary edema, hypokalemia, and hyperglycemia
- Fetal or newborn adverse effects: Fetal tachycardia

Magnesium Sulfate

- Maternal side effects: Causes flushing, diaphoresis, nausea, loss of deep tendon reflexes, respiratory depression, and cardiac arrest; suppresses heart rate, contractility and left ventricular systolic pressure when used with calcium channel blockers; and produces neuromuscular blockade when used with calcium channel blockers.
- Fetal or newborn adverse effects: Neonatal depression. (The use of magnesium sulfate in doses and duration for fetal neuroprotection alone does not appear to be associated with an increased risk of neonatal depression when correlated with cord blood magnesium levels.)

Regulatory Status

Ritodrine was approved by the U.S. Food and Drug Administration (FDA) for use as a tocolytic agent. Ritodrine was voluntarily withdrawn from the U.S. market in 1998.

Terbutaline is FDA approved for the prevention and treatment of bronchospasm in patients with asthma and reversible bronchospasm associated with bronchitis and emphysema. Like other tocolytic agents, its use in tocolysis is off-label. In response to a citizen petition in June, 2008, the FDA reviewed safety data on terbutaline sulfate. They issued a safety announcement on February 17, 2011. Based on animal studies, the FDA reclassified terbutaline from pregnancy risk category B to pregnancy risk category C. In addition, the FDA required a boxed warning stating that injectable terbutaline should not be used for prevention or prolonged (beyond 2-3
days) treatment of preterm labor, and oral terbutaline should not be used for acute or maintenance tocolysis. The labeling change is based on a review of post marketing safety reports submitted to the FDA’s Adverse Event Reporting System (AERS) of maternal death and serious maternal cardiovascular events associated with use of terbutaline.

IV. RATIONALE

Most recently, the literature was reviewed through September 8, 2015. Following is a summary of the literature to date.

Acute Tocolysis

Studies have focused on the ability of tocolytic agents to prevent preterm delivery and thereby to reduce associated maternal and neonatal risks. Numerous randomized controlled trials (RCTs) on acute tocolysis have been published and, in 2009, Haas et al conducted a comprehensive meta-analysis of RCTs. The investigators included 58 studies that directly compared different tocolytic medications or compared 1 medication with placebo or usual care. Studies were included if they compared 2 drugs in the same class but excluded if they included 2 doses of the same medication. Participants were women diagnosed with preterm labor or threatened preterm labor. The analysis was limited to studies with fetuses of mean gestational ages between 28 and 32 weeks of gestation. Multiple gestation was not an exclusion criterion, but if trials stratified on this variable, only data on singleton pregnancies were used. Data were extracted for each outcome and combined by drug class to calculate a weighted mean and standard error for proportions of successful events; proportions were weighted based on the number of participants in each study. Primary efficacy and safety outcomes are as follows in Tables 1 and 2.

### Table 1. Effect of Tocolytics on Delaying Birth (Weighted Percentage of Women Experiencing Outcome)

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>48-Hour Delay</th>
<th>7-Day Delay</th>
<th>After 37 Weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of Studies</td>
<td>% (95% CI)</td>
<td>No. of Studies</td>
</tr>
<tr>
<td>Placebo/control</td>
<td>9</td>
<td>53% (45 to 61)</td>
<td>8</td>
</tr>
<tr>
<td>Betamimetics</td>
<td>29</td>
<td>75% (65 to 85)</td>
<td>26</td>
</tr>
<tr>
<td>Calcium channel blockers</td>
<td>17</td>
<td>76% (57 to 95)</td>
<td>10</td>
</tr>
<tr>
<td>Magnesium sulfate</td>
<td>11</td>
<td>89% (85 to 93)</td>
<td>5</td>
</tr>
<tr>
<td>Oxytocin receptor antagonists</td>
<td>8</td>
<td>86% (80 to 91)</td>
<td>6</td>
</tr>
<tr>
<td>Prostaglandin inhibitors</td>
<td>6</td>
<td>93% (90 to 95)</td>
<td>3</td>
</tr>
</tbody>
</table>

Cl: confidence interval.
All tocolytic agents were significantly better than placebo/control at delaying delivery for 48 hours 7 days. None was significantly better than placebo/control at delaying delivery until after 37 weeks of gestation. The rate of discontinuation due to adverse effects was significantly higher for betamimetics than placebo/control but not for any of the other categories of medication.

As part of their review, the investigators conducted a decision analysis to determine the optimal medication based on the balance of benefits and risks. The decision analysis model found that prostaglandin inhibitors might be the superior agent up to 32 weeks of gestation due to a high effectiveness at delaying delivery by at least 7 days and a low rate of adverse effects. Calcium channel blockers were the superior agent for delaying delivery until 37 weeks. Compared with other tocolytics, calcium channel blockers reduced the incidence of birth within 7 days of treatment (relative risk [RR], 0.76; 95% confidence interval [CI], 0.60 to 0.97) and before 34 weeks of gestation (RR=0.83; 95% CI, 0.69 to 0.99).

In an additional study published in 2012, Haas et al conducted a network meta-analysis in which direct and indirect evidence on relative impacts of tocolytics on health outcomes were pooled simultaneously. Consequently, the analysis was not limited to comparisons in head-to-head trials that the research team had addressed in 2009. The investigators identified 95 RCTs; 25 contained a placebo arm, 60 included betamimetics, 29 included magnesium sulfate, 29 included calcium channel blockers, 18 included prostaglandin inhibitors, 13 included oxytocin receptor blockers, 4 included nitrates, and 5 included “other” drugs. The authors assumed that all drugs in the same class had a similar effect.

Fifty-five studies were included in the network analysis for the primary efficacy outcome, delivery delayed by 48 hours. All active classes were found to be superior to placebo. The analysis also suggested that prostaglandin inhibitors had a greater beneficial effect than any other active class of medication, and calcium channel blockers and magnesium sulfate had a greater beneficial effect than oxytocin receptor blockers, nitrates, and betamimetics. Prostaglandin inhibitors had an 83% probability of being the “best” class of active medications. The probability of being ranked among the 3 most efficacious classes was 96% for prostaglandin inhibitors, 63% for magnesium sulfate, 57% for calcium channel blockers, 33% for betamimetics, 24% for nitrates, and 14% for oxytocin receptor blockers.
Forty trials were included in the network analysis for the outcome neonatal mortality. There was no clear evidence for any class of medication being superior to placebo. Calcium channel blockers were found to be the “best” class, but the probability was only 41%, which reflects the considerable uncertainty in the estimate. Prostaglandin inhibitors had a 28% chance of being the “best” class, which was the second highest probability of any class. Similarly, calcium channel blockers were the “best” class for reducing neonatal respiratory distress syndrome (RDS), but the probability was only 47%. Fifty-eight trials were included in the network analysis for the outcome all-cause maternal side effects. Other than placebo, prostaglandin inhibitors had a 79% chance of being the drug class with the fewest maternal side effects. This was followed by oxytocin receptor blockers, which had a 70% probability of the class with the lowest rate of maternal side effects. Calcium channel blockers had a 15% chance of being included in the top 3 drug classes for the fewest maternal side effects. Overall, prostaglandin inhibitors and calcium channel blockers had the highest probability of being the best classes of medication based on all 4 outcome measures: delivery delayed by 48 hours, neonatal mortality, neonatal RDS, and maternal side effects.

There are also meta-analyses on acute tocolysis, focusing on a single tocolytic class or agent. In 2011, Conde-Agudelo et al reviewed trials on nifedipine, a calcium channel blocker. The investigators identified 26 randomized trials with 2179 women comparing nifedipine with placebo, no treatment, or a different tocolytic agent. Twenty-three trials evaluated acute tocolysis and 3 evaluated maintenance tocolysis (maintenance tocolysis is discussed later in the Rationale section). Findings were mixed. Pooled analyses of trials comparing nifedipine and beta-agonists found significantly lower rates of delivery within 7 days of treatment (10 trials; RR=0.82; 95% CI, 0.70 to 0.97) and preterm birth before 34 weeks of gestation (5 trials; RR=0.77; 95% CI, 0.66 to 0.91), but no significant difference in the rate of preterm delivery within 48 hours of treatment (13 trials; RR=0.84, 95% CI, 0.68 to 1.05) or preterm delivery before 37 weeks of gestation (9 trials; RR=0.97; 95% CI, 0.87 to 1.08). There were no significant differences in any of the preterm delivery variables when nifedipine was compared with magnesium sulfate, but the number of trials and total sample sizes were small, making it difficult to draw conclusions about comparative efficacy.

Several Cochrane reviews on a single type of tocolytic agent are available and are described briefly next.

A 2014 review identified 38 trials evaluating calcium channel blockers for tocolysis (total N=3550 women). The calcium channel blocker was nifedipine in 35 trials and nicardipine in the other 3. Thirty-five trials used other tocolytic agents as the comparator (19 used betamimetics), 1 compared doses of nifedipine, and the other 2 compared calcium channel blockers with placebo or no intervention. Only 1 trial was double-blinded. The authors evaluated several primary and secondary outcomes and conducted pooled analyses when sufficient data were available. Findings were mixed among primary outcomes, but several favored calcium channel blockers over betamimetics. There was a significantly lower rate of “very preterm birth” before 34 weeks of gestation with calcium channel blockers compared with betamimetics (6 trials; RR=0.78; 95% CI, 0.66 to 0.93) and a significantly lower rate of
maternal adverse effects (15 trials; RR=0.36; 95% CI, 0.24 to 0.53). The incidence of birth less than 48 hours after trial entry and the rate of perinatal mortality did not differ significantly between calcium channel blockers and other tocolytic agents. Among secondary outcome measures, there was a significantly lower rate of preterm birth before completion of 37 weeks of gestation with calcium channel blockers compared with betamimetics (13 trials; RR=0.89; 95% CI, 0.80 to 0.98), and there were too few studies to compare with other tocolytic agents. The authors noted that the quality of studies (e.g., lack of blinding, limited placebo controls), limited the ability to draw firm conclusions about the efficacy of calcium channel blockers compared with other tocolytic agents.

A 2014 updated Cochrane review identified 14 trials on oxytocin inhibitors (total N=2485 women). The control intervention was placebo in 4 trials, betamimetics in 8 trials, and a calcium channel blocker in 2 studies. Pooled analyses did not demonstrate the superiority of oxytocin receptor antagonists over betamimetics or placebo in terms of reduction in preterm birth or adverse neonatal outcomes. (Note: Oxytocin inhibitors are not approved by the Food and Drug Administration for use in the United States.)

Another 2014 Cochrane review identified 37 trials (total N=3571 women). Comparison interventions included other tocolytic drugs, predominantly betamimetics, nitroglycerine, human chorionic gonadotropin, saline, and dextrose. No placebo-controlled trials were identified. Pooled analyses found no statistically significant differences between magnesium sulfate and comparator interventions for outcomes including birth less than 48 hours after trial entry, serious infant adverse events, and preterm birth before 37 weeks of gestation.

A 2005 Cochrane review by King et al included 13 trials on cyclooxygenase (COX) inhibitors (total N=713 women); indomethacin was used in 10 of the trials. Only 1 trial compared COX inhibitors with placebo. Pooled analysis of studies comparing COX inhibitors with other tocolytics found a significant reduction in the incidence of birth before 37 weeks of gestation (RR=0.53; 54 women). The authors noted that numbers were small, and thus estimates were imprecise and not definitive.

In addition to these reviews of single agents, in 2014 Vogel et al published a Cochrane review on combinations of tocolytic agents for preventing preterm labor. The investigators searched for RCTs comparing any combination of tocolytic agents with any other treatment (including other combinations, single tocolytic agents, no intervention, or placebo). Eleven trials evaluating 7 different comparisons met the review’s inclusion criteria; 2 of these did not report relevant outcome data. Thus, few studies with small combined sample sizes were available for analysis, and the authors were unable to pool data or draw conclusions about the safety and efficacy of any combination of tocolytics versus any comparator intervention.

**Section Summary: Acute Tocolysis**

Multiple RCTs and meta-analyses have found tocolytics to be effective at decreasing rates of preterm birth in women with preterm labor (e.g., delaying delivery for 7 days and/or decreasing rates of delivery before 34 or 37 weeks of gestation). The optimal first-line medication is uncertain. A 2012 network meta-analyses suggests that prostaglandin inhibitors...
and calcium channel blockers may have greater efficacy and fewer adverse effects than other classes of medication. However, there was considerable uncertainty in the estimates of which class of medication was “best” for each outcome. Cochrane reviews of various tocolytic agents have not found any agent to be clearly superior to any other agent.

**Maintenance of Tocolysis**

Several meta-analyses of the published literature have been published. The 2011 Conde-Agudelo et al meta-analysis, described earlier, included 3 studies evaluating the calcium channel blocker nifedipine for maintenance tocolysis. A pooled analysis of these 3 trials (total N=215 patients) did not find a significant difference in the rate of preterm birth before 37 weeks of gestation with nifedipine compared with placebo or no treatment (RR=0.87; 97% CI, 0.69 to 1.08). There were insufficient data to conduct pooled analyses on other pregnancy outcome variables.

In 2009, a Health Technology Assessment from the U.K. addressed a wider range of maintenance tocolytic agents. However, for the outcomes prevention of preterm birth before 34 or 37 weeks of gestation, there were only a sufficient number of trials to conduct pooled analyses for 2 comparisons. Neither analysis found a statistically significant benefit of tocolysis. In a pooled analysis comparing magnesium maintenance therapy with other tocolytic agents, the combined RR was 0.98 (95% CI, 0.56 to 1.72). In addition, a pooled analysis of 4 trials (total N=384 patients) did not find a significant benefit of oral betamimetics compared with placebo or no treatment for preventing preterm birth before 37 weeks of gestation. The combined RR was 1.08 (95% CI, 0.88 to 1.22).

Several Cochrane reviews have addressed specific agents used for maintenance therapy and are described briefly next.

A 2013 Cochrane review of maintenance therapy with oxytocin antagonists identified only 1 trial. This trial, published in 2000 by Valenzuela et al, did not find that atosiban reduced the rate of preterm birth after threatened preterm birth compared with placebo. Another 2013 Cochrane review identified 6 RCTs on maintenance therapy with calcium channel blockers. Nifedipine was used in all trials and a total of 794 women were included. The comparison intervention was placebo in 3 trials and no treatment in the other 3 trials. Pooled analyses did not find that calcium channel blockers significantly reduced the rate of preterm birth before 37 weeks (5 trials; RR=0.97; 95% CI, 0.87 to 1.09) or 34 weeks (3 trials; RR=1.07; 95% CI, 0.88 to 1.30). A pooled analysis of 2 trials did not find significant differences between calcium channel blockers and controls for the outcome birth within 48 hours of treatment. There were insufficient data to draw conclusions about other outcomes. In 2015, follow-up data were published from an RCT evaluating maintenance tocolysis with nifedipine. Two-year outcome data were available for 135 of 276 (52.5%) participants. Outcomes were mixed for infants of women in the nifedipine maintenance group compared with the placebo group. Those with nifedipine maintenance had a higher incidence of fine motor problems (22% vs 8%, odds ratio, 3.43; 95% CI, 1.29 to 9.14) and a lower incidence of poor problem-solving ability (22% vs 29%; odds ratio, 0.27; 95% CI, 0.08 to 0.95).
In 2012, Dodd et al published a Cochrane review on oral betamimetics for maintenance tocolysis after threatened preterm labor. They identified 13 RCTs, some of which had more than 2 arms. There were 10 comparisons of a betamimetic and placebo or no treatment, 1 comparison of a betamimetic and indomethacin, 1 comparison between 2 different betamimetics, and 3 comparisons between a betamimetic and magnesium. Data could not be pooled for all outcomes due to a shortage of studies on a particular comparison. In a pooled analysis of 6 studies, there was no statistically significant difference in the rate of preterm birth before 37 weeks in patients receiving a maintenance betamimetic versus placebo or no treatment (RR=1.11; 95% CI, 0.91 to 1.35). In other pooled analysis of findings from studies comparing maintenance betamimetics with placebo or no treatment, there were no statistically significant differences between groups in birthweight (7 studies; mean difference, 4.13; 95% CI, -9.89 to 100.16), risk of perinatal mortality (6 studies; RR=2.41; 95% CI, 0.86 to 6.74), or risk of RDS in infants (6 studies; RR=1.10; 95% CI, 0.61 to 1.98).

A 2010 review by Han et al evaluated magnesium maintenance therapy and did not find a statistically significant effect of magnesium maintenance therapy on prevention of preterm birth before 37 weeks of gestation. A meta-analysis of 2 studies (total N=99 patients) that compared magnesium therapy with placebo or no treatment found a combined risk ratio of 1.05 (99% CI, 0.80 to 1.40). Two studies (total N=100 patients) were also available for a meta-analysis of studies comparing magnesium therapy with an alternative treatment. In this analysis, the combined RR was 0.99 (95% CI, 0.57 to 1.72).

Section Summary: Maintenance of Tocolysis
There are fewer RCTs on maintenance tocolysis compared with acute tocolysis. RCTs and meta-analyses on maintenance tocolysis have generally not found that tocolytic agents significantly improve health outcomes. Moreover, there are insufficient data from placebo-controlled trials.

Risks Associated With Terbutaline
An FDA-conducted search of its Adverse Event Reporting System (AERS) identified reports of 16 maternal deaths associated with terbutaline between 1976 and 2009. FDA documents stated that, in 3 cases, it was specified that terbutaline was administered by a subcutaneous pump, and in 9 cases oral terbutaline was used instead of or in addition to injectable or subcutaneous terbutaline. (Presumably, in the remaining cases, the mode of administration was not reported.) Moreover, between 1998 and July 2009, 12 cases of serious maternal cardiovascular events associated with terbutaline were submitted to AERS; in 3 cases, subcutaneous terbutaline was specified and, in 5 cases, oral terbutaline was used alone or in addition to subcutaneous terbutaline.

A 2011 commentary examined the human and animal evidence on risks of autism spectrum disorders associated with terbutaline. The authors concluded that the literature does not support the hypothesis that β2-adrenergic agonists including terbutaline are associated with autism spectrum disorders in offspring.
Ongoing and Unpublished Clinical Trials
A search of ClinicalTrials.gov in September 2015 did not identify any ongoing or unpublished trials that would likely influence this review.

Summary of Evidence
The evidence on acute tocolytic therapy for preterm labor includes multiple randomized controlled trials (RCTs) and meta-analyses. Relevant outcomes are overall survival, morbid events, functional outcomes, and treatment-related morbidity. Overall, the body of evidence found that the commonly used tocolytic agents presented herein are effective at inducing tocolysis in patients with preterm labor or threatened preterm labor. Data suggest that oral terbutaline is associated with more adverse events than parenteral terbutaline for acute tocolysis. Each medication has a different risk-benefit profile, and there is no clear first-line tocolytic agent. The evidence is sufficient to determine quantitatively that the technology results in a meaningful improvement in the net health outcome.

The evidence on maintenance tocolytic therapy after successful acute tocolysis includes RCTs and meta-analyses. Relevant outcomes are overall survival, morbid events, functional outcomes, and treatment-related morbidity. Studies have generally not found that maintenance tocolysis lowers the rate of preterm birth or perinatal mortality, or increases the birthweight. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical Input Received From Physician Specialty Societies and Academic Medical Centers
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted. In response to requests, input was received through 2 physician specialty societies and 4 academic medical centers while this policy was under review in 2012. There was consensus that acute tocolysis may be considered medically necessary for the induction of tocolysis in patients with preterm labor and near consensus that preterm should be defined as “<37 weeks” gestational age. There was mixed input on the investigational policy statement on maintenance tocolysis (beyond 48-72 hours).

Practice Guidelines and Position Statements
American College of Obstetricians and Gynecologists
The American College of Obstetricians and Gynecologists’ 2012 Management of Preterm Labor practice, reaffirmed in 2014,\(^1\) contains the following recommendations based on “good and consistent” scientific evidence:

- “A single course of corticosteroids is recommended for pregnant women between 24 weeks of gestation and 34 weeks of gestation who are at risk of preterm delivery within 7 days.
- Accumulated available evidence suggests that magnesium sulfate reduces the severity and risk of cerebral palsy in surviving infants if administered when birth is anticipated.
before 32 weeks of gestation. Hospitals that elect to use magnesium sulfate for fetal neuroprotection should develop uniform and specific guidelines for their departments regarding inclusion criteria, treatment regimens, concurrent tocolysis, and monitoring in accordance with one of the larger trials.

- The evidence supports the use of first-line tocolytic treatment with beta-adrenergic agonist therapy, calcium channel blockers, or non-steroidal anti-inflammatory drugs (NSAIDs) for short-term prolongation of pregnancy (up to 48 hours) to allow for the administration of antenatal steroids.
- Maintenance therapy with tocolytics is ineffective for preventing preterm birth and improving neonatal outcomes and is not recommended for this purpose.
- Antibiotics should not be used to prolong gestation or improve neonatal outcomes in women with pre-term labor and intact membranes.”

Royal College of Obstetricians and Gynecologists
The Royal College of Obstetricians and Gynecologists evidence-based guideline (updated February 2011)\(^1\) on use of tocolysis for women in preterm labor included the following conclusions relevant to this evidence review:

- “There is no clear evidence that tocolytic drugs improve outcome and therefore it is reasonable not to use them. However, tocolysis should be considered if the few days gained would be put to good use, such as completing a course of corticosteroids or in utero transfer.
- “Nifedipine and atosiban have comparable effectiveness in delaying birth for up to seven days.
- “Compared with beta-agonists, nifedipine is associated with improvement in neonatal outcome, although there are no long-term data.
- “Beta-agonists have a high frequency of adverse effects. Nifedipine, atosiban and the COX inhibitors have fewer types of adverse effects, and they occur less frequently than for beta-agonists but how they compare with each other is unclear.
- “There is insufficient evidence for any firm conclusions about whether or not tocolysis leads to benefit in preterm labor in multiple pregnancy.
- “There is insufficient evidence for any firm conclusion about whether or not maintenance tocolytic therapy following threatened preterm labor is worthwhile. Thus, maintenance therapy is not recommended.”

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination (NCD).
V. DEFINITIONS

**Preterm Labor** is labor that begins before completion of thirty-four (37) weeks from the last menstrual period.

**Subcutaneous** refers to beneath the skin.

**Subcutaneous Infusion** is the injection of an isotonic or hypotonic solution into the subcutaneous tissue to supply a continuous and large amount of fluid, electrolytes and nutrients.

**Tocolysis** Refers to the inhibition of uterine contractions.

VI. BENEFIT VARIATIONS

The existence of this medical policy does not mean that this service is a covered benefit under the member’s contract. Benefit determinations should be based in all cases on the applicable contract language. Medical policies do not constitute a description of benefits. A member’s individual or group customer benefits govern which services are covered, which are excluded, and which are subject to benefit limits and which require preauthorization. Members and providers should consult the member’s benefit information or contact Capital for benefit information.

VII. DISCLAIMER

Capital’s medical policies are developed to assist in administering a member’s benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member’s benefit information, the benefit information will govern. Capital considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.
Covered when medically necessary:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>J3105</td>
<td>Injection, Terbutaline Sulfate, up to 1 mg</td>
</tr>
<tr>
<td>J3475</td>
<td>Injection, Magnesium Sulphate, per 500 mg</td>
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<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis Codes</th>
<th>Description</th>
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<tbody>
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<td>False labor before 37 completed weeks of gestation, second trimester</td>
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<tr>
<td>O47.03</td>
<td>False labor before 37 completed weeks of gestation, third trimester</td>
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<tr>
<td>O60.02</td>
<td>Preterm labor without delivery, second trimester</td>
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<td>O60.03</td>
<td>Preterm labor without delivery, third trimester</td>
</tr>
</tbody>
</table>

*If applicable, please see Medicare LCD or NCD for additional covered diagnoses.

IX. REFERENCES


**Other Sources:**
Taber’s Cyclopedic Medical Dictionary, 19th edition.

**X. Policy History**

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<tr>
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<td></td>
<td>CAC 2/28/06 Consensus Review</td>
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<td>Minor revision. Policy retitled Acute and Maintenance Tocolysis. Agents other than terbutaline are now addressed.</td>
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<td>Policy statements revised to reflect boxed warnings regarding terbutaline issued 2/17/11.</td>
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<tr>
<td>CAC 4/24/12 and 6/26/12</td>
<td>Adopt BCBSA. The use of acute tocolytic agents was revised for induction of tocolysis in patients with preterm labor from &lt;34 weeks to &lt;37 weeks’ gestational age. Policy again discussed during June CAC. Decision stands regarding induction of tocolysis for preterm labor from &lt;34 weeks to &lt;37 weeks. Administrative code review complete.</td>
</tr>
<tr>
<td>CAC 7/22/14</td>
<td>Consensus No change to policy statements. Policy guidelines and rationale section added. Coding reviewed.</td>
</tr>
<tr>
<td>CAC 7/21/15</td>
<td>Consensus review. No changes to the policy statements. References and rationale updated. Policy coded.</td>
</tr>
<tr>
<td>CAC 7/26/16</td>
<td>Consensus review. No changes to the policy statements. References and rationale updated. Coding reviewed.</td>
</tr>
<tr>
<td>Administrative Update 11/23/16</td>
<td>Variation reformatting.</td>
</tr>
</tbody>
</table>