

OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION REQUEST FORM*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to **757-552-7429 or 1-877-800-2839**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.

Drug Name: **Botulinum Toxin Injections (Botox) (Code J-0585)**

- Botox injections are used to effect change in the nerve conduction systems involved in select chronic disorders including: localized spastic disorders, ocular motor problems and hyperhidrosis.
- Botox acts through blocking action on the nerve synapse, which is used to reduce spasm/associated pain, correct control of motor function and reduce sweating.
- Botox injections are also used to reduce skeletal and gastrointestinal muscle spasms by weakening abnormally contracting muscles and for the treatment of chronic anal fissure.
- Safety for Botox use during pregnancy or lactation has not been established.
- Contraindications: demonstrate allergies to Botox, have infection/inflammation at the injection site, diseases of neuromuscular transmission, have anti-Botox antibodies and do not respond to repeated injections, coagulopathy (including therapeutic anticoagulation), unable to cooperate and acquire nystagmus

Diagnosis:

(Check one)

- | | |
|--|--|
| <input type="checkbox"/> Blepharospasm | <input type="checkbox"/> CVA within 1 year of onset |
| <input type="checkbox"/> Cervical Dystonia (spasmodic torticollis) and Mixed Cervical Dystonia | <input type="checkbox"/> Hirschsprung's Disease |
| <input type="checkbox"/> Hand Dystonia | <input type="checkbox"/> Spastic Hemiplegia |
| <input type="checkbox"/> Hemifacial spasm | <input type="checkbox"/> Spastic Paraplegia |
| <input type="checkbox"/> Hyperhidrosis (axillary, palmar, or gustatory only) | <input type="checkbox"/> Spastic Diplegia |
| <input type="checkbox"/> Laryngeal Dysphonia – Spastic | <input type="checkbox"/> Spastic Quadriplegia |
| <input type="checkbox"/> Laryngeal Dystonia (adductor spasmodic dysphonia) | <input type="checkbox"/> Upper Extremity Spasticity |
| <input type="checkbox"/> Laryngeal Spasm | <input type="checkbox"/> Drooling in Parkinson's Disease |
| <input type="checkbox"/> Orofacial Dyskinesia | <input type="checkbox"/> Neurogenic detrusor overactivity |
| <input type="checkbox"/> Strabismus | <input type="checkbox"/> Motor tics |
| <input type="checkbox"/> Synkinetic Eyelid Closure – VII Cranial Nerve | <input type="checkbox"/> Essential hand tremor in patients who fail oral agents |
| <input type="checkbox"/> Torticollis | <input type="checkbox"/> Chronic predominantly unilateral low back pain |
| <input type="checkbox"/> Achalasia, Primary | **Patient must have tried <u>ALL</u> of the following: |
| <input type="checkbox"/> Anal Fissure – Chronic | <input type="checkbox"/> PT/OT |
| <input type="checkbox"/> Cerebral Palsy – Dynamic Contracture | <input type="checkbox"/> Alternative therapies or lifestyle changes (massage, weight loss, etc...) |
| | <input type="checkbox"/> Use of APAP, NSAIDs, muscle relaxants, narcotics |

Please complete below:

(ALL lines must be checked to qualify)

- Must be resistant to conventional medical treatment (e.g. topical antiperspirants, anticholinergic medications, etc.)
- Injections done in lieu of coverage for surgery (strabismus indication)

Patient _____

Member Number _____

Signed _____ Date _____

***Medical notes must be submitted to support each line checked on this request.**

Physician Name _____

Phone Number _____

Fax Number _____

Pharmacy Name and phone number _____