

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

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; fax to 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.

Drug Requested: Botulinum Toxin Injections®, Type A

Botox® (onabotulinumtoxinA) (J0585) - Hyperhidrosis

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug From/Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

- Max quantity limits: 400 units in a 3-month period
- *Cosmetic indications are excluded.*

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

CLINICAL CRITERIA: Check one of the diagnosis below. Appropriate lines **MUST** be checked to ensure the authorization process will **NOT** be delayed.

Primary Axillary Hyperhidrosis as defined by having:

Visible, excessive sweating for at least six (6) months, **PLUS** two (2) of the following:

- Bilateral, symmetric sweating
- Impairment of daily activities
- At least one episode per week
- Onset before 25 years of age
- Positive family history
- Cessation of focal sweating during sleep

Patients must have met **ALL** the following criteria:

- Adequate trial and failure of topical antiperspirants (i.e. aluminum chloride hexahydrate 20% such as Certain Dri® [OTC], Drysol®, Hypercare®, Xerac® AC [OTC])
- Adequate trial and failure of at least one (1) systemic anticholinergic drug (glypyrrolate, oxybutynin, clonidine) verified by claims data from the past six (6) months.

Palmoplantar Hyperhidrosis as defined by:

Patients must have met **ALL** the following criteria:

- Adequate trial and failure of topical antiperspirants (i.e. aluminum chloride hexahydrate 20% such as Certain Dri® [OTC], Drysol®, Hypercare®, Xerac® AC [OTC])
- Adequate trial and failure of at iontophoresis

(signature on next page)

Medication being provided by (check applicable box below):

Physician's office

OR

Specialty Pharmacy - PropriumRx

*****Use of samples to initiate therapy does not meet step edit/preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018