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)**
{Upper Limb Spasticity (ULS) & Lower Limb Spasticity (LLS)} (Medical)

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

Drug Form/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 diagnoses below. All appropriate lines must be checked to ensure the authorization will NOT be delayed.

- ❑ **Single Arm Upper Limb Spasticity**

  OR

- ❑ **Both Arms Upper Limb Spasticity**
  - ❑ ***Anterior Arm***
    - ❑ Biceps Brachii (100-200 units divided in 4 sites)
    - ❑ Flexor Carpi Radialis (12.5 - 50 units)
    - ❑ Flexor Carpi Ulnaris (12.5 – 50 units)
    - ❑ Flexor Pollicis Longus (20 units)
  - ❑ ***Posterior Arm***
    - ❑ Flexor Digitorum Profundus (30-50 units)
    - ❑ Flexor Digitorum Sublimis (30-50 units)
  - ❑ ***Adductor Pollicis*** (20 units)

- ❑ **Lower Limb Spasticity** ***(300 – 400 units divided among 5 muscles)***
  - ❑ Gastrocnemius Medial Head (75 units)
  - ❑ Gastrocnemius Lateral Head (75 units)
  - ❑ Soleus (75 units)
  - ❑ Tibialis Posterior (75 units)
  - ❑ Flexor Halluces Longus (50 units)
  - ❑ Flexor Digitorum Longus (50 units)

(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 charts.

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