

# 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 B**  
**Myobloc® (rimabotulinumtoxinB) (J0587) (Medical)**

**DRUG INFORMATION:** Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength/Month: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

*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. To qualify, ALL lines that apply must be checked.

- Cervical Dystonia (spasmodic torticollis) and Mixed Cervical Dystonia
  - Initial Dose
    - Botulinum-Naïve Patients: 2500 units intramuscularly in divided doses among affected muscles
    - Botulinum-Experienced Patients: 2500-5000 units intramuscularly in divided doses among affected muscles
  - Max total dose: 10000 units in 12 week period
  - Re-treatment interval should not be less than 12 weeks
- Drooling due to neurologic diseases (i.e. ALS, Parkinson's disease, cerebral palsy, multiple sclerosis)
  - Dose: 250-1000 units per gland (max 1 injection per side)
  - Interval Between Treatments: 16-24 weeks

**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: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_

REVISED/UPDATED: 7/1/2018