

**OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)**

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 1-844-348-3720**. 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)
(Chronic Migraine Headache Prophylaxis)**

DRUG INFORMATION: Complete information below or authorization 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.**

CLINICAL CRITERIA FOR CHRONIC MIGRAINE HEADACHE PROPHYLAXIS:
All boxes below **MUST** be checked to ensure authorization will **NOT** be delayed. Medical notes/charts **MUST** be included with this request.

- Patients must have met **ALL** the following criteria:
 - Headaches \geq 15 days/month
 - Headaches last \geq 4 hours/day
 - Trial and failure **to at least 3 migraine prophylaxis drugs of different classes within the last 12 months. (PREVIOUS THERAPIES WILL BE VERIFIED THROUGH PHARMACY PAID CLAIMS OR SUBMITTED CHART NOTES.)**
 - Anticonvulsants (divalproex, valproate, topiramate)
 - Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
 - Antidepressants (amitriptyline, venlafaxine)
 - Predominant rescue medication is **NOT** an opioid

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

Medication being provided by (check applicable box below):

- Physician's office **OR** Specialty Pharmacy - PropriumRx

(Continued on next page; signature page **MUST** be attached with this request form)

(Signature page **MUST** be included with request form)

****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 #: _____

*Approved by Pharmacy and Therapeutics Committee: 7/19/2018
REVISED/UPDATED: 9/27/2018