OPTIMA HEALTH 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 1-844-723-2094.** 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.**

Botulinum Toxin Injections®, Type A (Medical)

Drug Requested - check applicable drug below:	
❑ **Botox®** (onabotulinumtoxinA) **(J0585)**	❑ **Xeomin®** (incobotulinumtoxinA) **(J0588)**

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

Drug Name/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: Check **one** of the diagnoses below. Applicable box(es) **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

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

❑ **Achalasia, Primary idiopathic esophageal**

- ❑ The patient has failed or had a clinically significant adverse reaction to conventional therapy (nitrates or calcium channel blockers)

OR

- ❑ The patient ineligible for surgical treatment due to advance age or multiple co-morbidities (poor surgical risk)

OR

- ❑ The patient is at high risk of complications of pneumatic dilation or surgical myotome

OR

- ❑ Failure of prior myotomy or dilation

OR

- ❑ The patient has an epiphrenic diverticulum or hiatal hernia, both of which increase the risk of dilation-induced perforation

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❑ **Achalasia, Internal anal sphincter (IAS)**

- ❑ Patient has not responded to treatment with laxatives

AND

- ❑ Patient has not responded to or is not a candidate for anal sphincter myectomy

❑ **Anal Fissure – Chronic**

- ❑ The patient has failed (at least 60 days) topical nitroglycerin or topical calcium channel blocker

❑ **Blepharospasm**

❑ **Cerebral Palsy** – Dynamic Contracture

❑ **Cerebral Palsy** – Spasticity (including diplegia, hemiplegia, paraplegia, or quadriplegia)

❑ **Cervical Dystonia** (spasmodic torticollis) and **Mixed Cervical Dystonia**

❑ **CVA-related spasticity** within 1 year of onset

❑ **Drooling in Parkinson's Disease**

- ❑ **Essential hand tremor in patients who fail oral agents**
- ❑ **Hand Dystonia**
- ❑ **Hemifacial spasm**
- ❑ **Hirschsprung's Disease**
- ❑ **Laryngeal Dysphonia – Spastic**
- ❑ **Laryngeal Dystonia** (adductor spasmodic dysphonia)
- ❑ **Laryngeal Spasm**
- ❑ **Motor tics**
- ❑ **Neurogenic detrusor overactivity and/or detrusor sphincter dyssynergia**
- ❑ **Orofacial Dyskinesia**
- ❑ **Overactive Bladder**

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

  - ❑ A diagnosis of incontinence
  - ❑ Symptoms of urge incontinence, urgency, and frequency (experienced at least 3 urinary incontinence episodes and at least 24 micturitions in 3 days)
  - ❑ 8-12 week trial and failure of behavioral therapy (e.g. bladder training, control strategies, pelvic floor muscle training, fluid management)
  - ❑ Failed or inadequate response to anticholinergic therapy within the last 9 months (4-8 week trial per agent)
  - ❑ 2 anticholinergic agents and 1 β-3 adenoreceptor agonist **(will require PA)**; or
  - ❑ 1 anticholinergic agent and 1 alpha blocker and 1 β-3 adenoreceptor agonist **(will require PA)**

    Please indicate drugs used:
    _____
    _____
- ❑ **Strabismus** (injections done in lieu of coverage for surgery)
- ❑ **Synkinetic Eyelid Closure – VII Cranial Nerve**
- ❑ **Torticollis**

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: ~~8/1/2017; 8/17/2018; 9/29/2018;~~ **(Reformatted) 2/4/2019**;