

**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) - Hyperhidrosis

DRUG INFORMATION. Complete information below or authorization process will be delay.

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 diagnosis. Appropriate lines **MUST** be checked to qualify to ensure authorization process will 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.

(continued on next page)

- 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

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; 10/8/2018;