OPTIMA HEALTH COMMUNITY 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 INFORMATON. 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.

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- ❑ **<u>Palmoplantar Hyperhidrosis</u>** 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;~~ **(Reformatted) 2/4/2019**