

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.

Drug Requested: **Botulinum Toxin Injections[®], Type A (Medical)**
 (BOTOX[®]) (onabotulinumtoxinA) (J0585)
{Upper Limb Spasticity (ULS) & Lower Limb Spasticity (LLS)}

DRUG INFORMATION: Complete all information below or authorization process 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.**

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

CLINICAL CRITERIA: Check one diagnosis below that applies to ensure authorization will **NOT** be delayed.

- Single Arm Upper Limb Spasticity** **OR** **Both Arms Upper Limb Spasticity**
 - Anterior Arm**
 - Biceps Brachii (100-200 units divided in 4 sites)
 - Flexor Carpi Radialis (12.5 - 50 units)
 - Flexor Carpi Ulnaris (12.5 – 50 units)
 - Flexor Pollicis Longus (20 units)
 - Posterior Arm**
 - Flexor Digitorum Profundus (30-50 units)
 - Flexor Digitorum Sublimis (30-50 units)
 - Adductor Pollicis** (20 units)
- Lower Limb Spasticity** (300 – 400 units divided among 5 muscles)
 - Gastrocnemius Medial Head (75 units)
 - Gastrocnemius Lateral Head (75 units)

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- Soleus (75 units)
- Tibialis Posterior (75 units)
- Flexor Halluces Longus (50 units)
- Flexor Digitorum Longus (50 units)

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 charts.

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; 12/20/2017; 8/17/2018; 10/8/2018; (Reformatted) 2/4/2019