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** **(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)

(continued on next page)

(continued from previous page)

- ❑ 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**