

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)**
Dysport® (abotulinumtoxinA) (J0586)

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

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

- **Cosmetic indications are excluded.**

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

CLINICAL CRITERIA: Check diagnosis below. Appropriate diagnosis **must** be identified to qualify. Authorization process will be delayed if incomplete.

Pediatric Lower Limb Spasticity >2 years old
(Total dose per treatment session would be 10 -15 units/kg for unilateral lower limb injections or 20 - 30 units/kg for bilateral lower limb injections.
Total dose administered per treatment session **must not** exceed 15 units/kg for unilateral lower limb injections or 30 units/kg for bilateral lower limb injections or 1000 units, whichever is lower.)

- **Interval between treatments:** 12-16 weeks, some patients had a longer duration of response
- Gastrocnemius: 6 to 9 units/kg (**up to 4 injections per muscle**)
- Soleus: 4 to 6 units/kg (**up to 2 injections per muscle**)
- Total 10-15 units/kg divided across both muscles (**up to 6 injections total**)

Adult Lower Limb Spasticity

- **Dose** should **not** exceed 1500 units divided among selected muscles per treatment session
- **Interval between Treatments:** no sooner than 12 weeks after the previous injection, majority of patients retreated between 12-16 weeks
- Gastrocnemius:
 - **Medial Head:** 100 units to 150 units (**1 injection per muscle**)
 - **Lateral Head:** 100 units to 150 units (**1 injection per muscle**)
- Soleus: 330 units to 500 units (**3 injection per muscle**)
- Tibialis posterior: 200 units to 300 units (**1 injection per muscle**)
- Flexor digitorum longus: 130 units to 200 units (**1 to 2 injections per muscle**)
- Flexor hallucis longus: 70 units to 200 units (**1 injection per muscle**)

(continued on next page)

Upper Limb Spasticity:

- **Dose:** 500 to 1,000 units divided among selected muscles
- **Interval between Treatments:** 12-16 weeks some patients had a longer duration of response (e.g., 20 weeks)
- Brachialis: 200 to 400 units (1 to 2 injections per muscle)
- Brachioradialis: 100 to 200 units (1 to 2 injections per muscle)
- Biceps brachii: 200 to 400 units (1 to 2 injections per muscle)
- Flexor carpi radialis: 100 to 200 units (1 to 2 injections per muscle)
- Flexor carpi ulnaris: 100 to 200 units (1 to 2 injections per muscle)
- Flexor digitorum profundus: 100 to 200 units (1 to 2 injections per muscle)
- Pronator teres: 100 to 200 units (1 injection per muscle)

Anal Fissures

- **Dose:** 90-150 units intramuscularly in 2 divided doses

Cervical Dystonia (spasmodic torticollis) and Mixed Cervical Dystonia

- **Initial Dose:** 500 units intramuscularly in divided doses among affected muscles
- Titrate in 250 unit increments for total dose (i.e. 500 units total → 750 units total) every 12 weeks
- **Max total dose:** 1000 units in 12 week period
- Re-treatment interval should not be less than 12 weeks

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

- Dose** Range: 8-30 units/kg in divided doses among affected muscles
- Max Dose Studied:** 750 units in divided doses among affected muscles

Drooling due to neurologic diseases (i.e. ALS, Parkinson’s disease, cerebral palsy, multiple sclerosis)

- **Dose:** 15-75 units per gland (max 2 injections per side)
- **Interval between Treatments:** 16-24 weeks

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: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____