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 B**
Myobloc® (rimabotulinumtoxinB) **(J0587) (Medical)**

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

Drug Form/Strength/Month: _____

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 one of the diagnoses below. To qualify, **ALL** lines that apply **must** be checked to ensure authorization will **NOT** be delayed.

- ❑ Cervical Dystonia (spasmodic torticollis) and Mixed Cervical Dystonia
  - Initial Dose
    - Botulinum-Naïve Patients: 2500 units intramuscularly in divided doses among affected muscles
    - Botulinum-Experienced Patients: 2500-5000 units intramuscularly in divided doses among affected muscles
  - Max total dose: 10000 units in 12 week period
  - Re-treatment interval should not be less than 12 weeks
- ❑ Drooling due to neurologic diseases (i.e. ALS, Parkinson's disease, cerebral palsy, multiple sclerosis)
  - Dose: 250-1000 units per gland (max 1 injection per side)
  - Interval Between Treatments: 16-24 weeks

Medication being provided by (check applicable box below)**:**

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

(continued on next page; signature MUST be attached with this request.)

(Signature page MUST be included with request.)

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 #: _____

REVISED/UPDATED: ~~8/1/2017;~~ ~~8/27/2018;~~ ~~10/8/2018;~~ **(Reformatted) 2/5/2019**;