OPTIMA HEALTH COMMUNITY CARE

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)**	❑ **Xeomin ®** (incobotulinumtoxinA) **(J0588)**

DRUG INFORMATON: Check applicable box below. Information must be complete or authorization process will be delayed.

Drug Name/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.***

CLINICAL CRITERIA: Check one of the diagnoses below. Applicable lines MUST be checked to qualify. Authorization process will be delayed if incomplete.

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

❑ **Achalasia, Primary idiopathic esophageal**
- ❑ The patient has failed or had a clinically significant adverse reaction to conventional therapy (nitrates or calcium channel blockers)

OR

- ❑ The patient ineligible for surgical treatment due to advance age or multiple co-morbidities (poor surgical risk)

OR

- ❑ The patient is at high risk of complications of pneumatic dilation or surgical myotome

OR

- ❑ Failure of prior myotomy or dilation

OR

- ❑ The patient has an epiphrenic diverticulum or hiatal hernia, both of which increase the risk of dilation-induced perforation

❑ **Achalasia, Internal anal sphincter (IAS)**
- ❑ Patient has not responded to treatment with laxatives

AND

- ❑ Patient has not responded to or is not a candidate for anal sphincter myectomy

❑ **Anal Fissure – Chronic**
- ❑ The patient has failed (at least 60 days) topical nitroglycerin or topical calcium channel blocker

❑ **Blepharospasm**

❑ **Cerebral Palsy – Dynamic Contracture**

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

❑ **Cervical Dystonia** (spasmodic torticollis) and **Mixed Cervical Dystonia**

❑ **Chronic Migraine Headache Prophylaxis**

Patients must have met ***ALL*** the following criteria:
- ❑ Headaches ≥ 15 days/month
- ❑ Headaches last ≥ 4 hours/day
- ❑ Current use of at least one migraine prophylaxis drug
- ❑ Predominant rescue medication is ***NOT*** an opioid

❑ **CVA-related spasticity** within 1 year of onset

❑ **Drooling in Parkinson's Disease**

❑ **Essential hand tremor in patients who fail oral agents**

❑ **Hand Dystonia**

❑ **Hemifacial spasm**

❑ **Hirschsprung's Disease**

❑ **Laryngeal Dysphonia – Spastic**

❑ **Laryngeal Dystonia** (adductor spasmodic dysphonia)

❑ **Laryngeal Spasm**

❑ **Motor tics**

❑ **Neurogenic detrussor overactivity and/or detrusor sphincter dyssynergia**

❑ **Orofacial Dyskinesia**

(continued on next page)

- ❑ **Overactive Bladder**
  Patients must have met ***ALL*** the following criteria:
  - ❑ A diagnosis of incontinence
  - ❑ Symptoms of urge incontinence, urgency, and frequency (experienced at least 3 urinary incontinence episodes and at least 24 micturitions in 3 days)
  - ❑ 8-12 week trial and failure of behavioral therapy (e.g. bladder training, control strategies, pelvic floor muscle training, fluid management)
  - ❑ Failed or inadequate response to anticholinergic therapy within the last 9 months (4-8 week trial per agent)
  - ❑ 2 anticholinergic agents and 1 β-3 adenoreceptor agonist ***(will require PA)***; or
    - ❑ 1 anticholinergic agent and 1 alpha blocker and 1 β-3 adenoreceptor agonist ***(will require PA)***
      Please indicate drugs used: _____
      _____
  - ❑ **Strabismus** (injections done in lieu of coverage for surgery)
  - ❑ **Synkinetic Eyelid Closure – VII Cranial Nerve**
  - ❑ **Torticollis**

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