

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 - Botox® (onabotulinumtoxinA) (J0585)
{Upper Limb Spasticity (ULS) & Lower Limb Spasticity (LLS)} (Medical)**

DRUG INFORMATION: Complete information below. If incomplete, 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.**

CLINICAL CRITERIA: Check one diagnosis below. All appropriate lines **must** be checked to qualify or authorization will be delayed.

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

Single Arm Upper Limb Spasticity
OR

Anterior Arm

- Biceps Brachii (100-200units)
- Flexor carpi radialis (12.5-50units)
- Flexor Digitorum profundus [hidden] (30-50 units)
- Flexor pollicis longus (20 units)
- Flexor digitorum superficialis (30-50 units)
- Adductor pollicis (20 units)

Both Arms Upper Limb Spasticity

Posterior Arm

- Biceps brachii (100-200 units)
- Flexor carpi radialis (12.5 -50 units)
- Adductor Pollicis (20 units)

Lower Limb Spasticity

- Ankle and toe muscles (300-400units)

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