

OPTIMA HEALTH PLAN

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 1-844-202-5034. 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 (please check one): **Botulinum Toxin Injections®, Type A**

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

Botox® (onabotulinumtoxinA) (J0585)

Xeomin® (incobotulinumtoxinA) (J0588)

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.****

- | | |
|--|--|
| <p><input type="checkbox"/> Achalasia, Primary idiopathic esophageal</p> <p><input type="checkbox"/> The patient has failed or had a clinically significant adverse reaction to conventional therapy (nitrates or calcium channel blockers)</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> The patient ineligible for surgical treatment due to advance age or multiple co-morbidities (poor surgical risk)</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> The patient is at high risk of complications of pneumatic dilation or surgical myotomy</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> Failure of prior myotomy or dilation</p> <p style="text-align: center;">OR</p> <p><input type="checkbox"/> The patient has an epiphrenic diverticulum or hiatal hernia, both of which increase the risk of dilation-induced perforation</p> <p><input type="checkbox"/> Achalasia, Internal anal sphincter (IAS)</p> <p><input type="checkbox"/> Patient has not responded to treatment with laxatives</p> <p style="text-align: center;">AND</p> <p><input type="checkbox"/> Patient has not responded to or is not a candidate for anal sphincter myectomy</p> <p><input type="checkbox"/> Anal Fissure – Chronic</p> <p><input type="checkbox"/> The patient has failed (at least 60 days) topical nitroglycerin or topical calcium channel blocker</p> <p><input type="checkbox"/> Blepharospasm</p> <p><input type="checkbox"/> Cerebral Palsy – Dynamic Contracture</p> <p><input type="checkbox"/> Cerebral Palsy – Spasticity (including diplegia, hemiplegia, paraplegia, or quadriplegia)</p> | <p><input type="checkbox"/> Cervical Dystonia (spasmodic torticollis) and Mixed Cervical Dystonia</p> <p><input type="checkbox"/> Chronic Migraine Headache Prophylaxis</p> <p>Patients must have met ALL the following criteria:</p> <p><input type="checkbox"/> Headaches \geq 15 days/month</p> <p><input type="checkbox"/> Headaches last \geq 4 hours/day</p> <p><input type="checkbox"/> Current use of at least one migraine prophylaxis drug</p> <p><input type="checkbox"/> Predominant rescue medication is NOT an opioid</p> <p><input type="checkbox"/> CVA-related spasticity within 1 year of onset</p> <p><input type="checkbox"/> Drooling in Parkinson's Disease</p> <p><input type="checkbox"/> Essential hand tremor in patients who fail oral agents</p> <p><input type="checkbox"/> Hand Dystonia</p> <p><input type="checkbox"/> Hemifacial spasm</p> <p><input type="checkbox"/> Hirschsprung's Disease</p> <p><input type="checkbox"/> Laryngeal Dysphonia – Spastic</p> <p><input type="checkbox"/> Laryngeal Dystonia (adductor spasmodic dysphonia)</p> <p><input type="checkbox"/> Laryngeal Spasm</p> <p><input type="checkbox"/> Motor tics</p> <p><input type="checkbox"/> Neurogenic detrusor overactivity and/or detrusor sphincter dyssynergia</p> <p><input type="checkbox"/> Orofacial Dyskinesia</p> |
|--|--|

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 adenosine receptor agonist (*will require PA*); or

- 1 anticholinergic agent and 1 alpha blocker and 1 β -3 adenosine receptor 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:**

- Briova SpecialtyRx**

****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 #: _____

*Approved by Pharmacy and Therapeutics Committee: 11/18/2010; 5/21/2015

REVISED/UPDATED: 8/11/2011; 8/22/2011; 8/30/2011; 3/28/2012; 4/19/2012; 3/21/2013; 4/11/2014; 8/20/2014; 10/31/2014; 4/3/2015; 5/23/2015; 8/15/2015; 12/28/2015; 1/29/2016; 3/31/2016; 7/21/2016; 8/12/2016; 9/22/2016; 11/14/2016; 12/21/2016; 9/12/2017; 10/4/2017