

# 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.**

### Botulinum Toxin Injections<sup>®</sup>, Type A (Medical)

<b>Drug Requested - check applicable drug below:</b>	
<input type="checkbox"/> <b>Botox<sup>®</sup></b> (onabotulinumtoxinA) (J0585)	<input type="checkbox"/> <b>Xeomin<sup>®</sup></b> (incobotulinumtoxinA) (J0588)

**DRUG INFORMATON:** Complete all information below or authorization 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 box(es) **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

**\*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**
- 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 detrusor overactivity and/or detrusor sphincter dyssynergia**
- Orofacial Dyskinesia**
- 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  $\beta$ -3 adenosine receptor agonist (**will require PA**); or
- 1 anticholinergic agent and 1 alpha blocker and 1  $\beta$ -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 - BriovaRx**

**\*\*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; 7/24/2017; 10/1/2018