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: Botulinum Toxin Injections®, Type A

❑ **Botox®** (onabotulinumtoxinA) **(J0585) – Hyperhidrosis**

DRUG INFORMATON. Complete information below. Authorization process will be delay if not completed.

Drug From/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code:** _____

- ***Max quantity limits: 400 units in a 3-month period***
- ***Cosmetic indications are excluded.***

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

CLINICAL CRITERIA: Check one diagnosis. Appropriate lines MUST be checked to qualify. Incomplete information will delay authorization process.

❑ ***Primary Axillary Hyperhidrosis*** **as defined by having:**

- ❑ Visible, excessive sweating for at least six (6) months, ***PLUS*** two (2) of the following:
  - ❑ Bilateral, symmetric sweating
  - ❑ Impairment of daily activities
  - ❑ At least one episode per week
  - ❑ Onset before 25 years of age
  - ❑ Positive family history
  - ❑ Cessation of focal sweating during sleep
- ❑ Patients must have met ***ALL*** the following criteria:
  - ❑ Adequate trial and failure of topical antiperspirants (i.e. aluminum chloride hexahydrate 20% such as Certain Dri® [OTC] , Drysol®, Hypercare®, Xerac® AC [OTC])
  - ❑ Adequate trial and failure of at least one (1) systemic anticholinergic drug (glypyrrolate, oxybutynin, clonidine) verified by claims data from the past six (6) months.

❑ ***Palmoplantar Hyperhidrosis*** **as defined by:**

- ❑ Patients must have met ***ALL*** the following criteria:
  - ❑ Adequate trial and failure of topical antiperspirants (i.e. aluminum chloride hexahydrate 20% such as Certain Dri® [OTC], Drysol®, Hypercare®, Xerac® AC [OTC])
  - ❑ Adequate trial and failure of at iontophoresis

(signature on next page)

***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**: 8/15/2015
REVISED/UPDATED: ~~11/20/2015~~; ~~12/29/2015~~; ~~1/29/2016~~; ~~9/20/2016~~; ~~11/16/2016~~; ~~12/12/2016~~; ~~9/17/2017~~; **10/4/2017**;