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 B**

Myobloc® (rimabotulinumtoxinB) **(J0587)**

DRUG INFORMATION:* *Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

Cosmetic indications are excluded.

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

CLINICAL CRITERIA:* *Check one of the diagnoses below. To qualify, ALL lines that apply must be checked.

- ❑ Cervical Dystonia (spasmodic torticollis) and Mixed Cervical Dystonia
  - Initial Dose
    - Botulinum-Naïve Patients: 2500 units intramuscularly in divided doses among affected muscles
    - Botulinum-Experienced Patients: 2500-5000 units intramuscularly in divided doses among affected muscles
  - ***Max total dose: 10000 units in 12 week period***
  - ***Re-treatment interval should not be less than 12 weeks***
- ❑ Drooling due to neurologic diseases ***(i.e. ALS, Parkinson's disease, cerebral palsy, multiple sclerosis)***
  - ***Dose: 250-1000 units per gland (max 1 injection per side)***
  - ***Interval Between Treatments: 16-24 weeks***

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: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 5//21/2015
REVISED/UPDATED: ~~7/1/2015; 8/11/2015; 12/30/2015; 1/29/2016; 8/18/2016; 9/22/2016; 11/29/2016; 12/13/2016; 9/15/2017;~~ **10/4/2017**;