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: Xeomin® (incobotulinumtoxinA) **(J0588)** ***Botulinum Toxin Injections®, Type A***

DRUG INFORMATON: Check applicable box below. Information must be complete or authorization process 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 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. *****

- ❑ **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**
- ❑ **Chronic Migraine Headache Prophylaxis**

  Patients must have met ***ALL*** the following criteria:
  - ❑ Headaches ≥ 15 days/month
  - ❑ Headaches last ≥ 4 hours/day
  - ❑ Current use of at least one migraine prophylaxis drug
  - ❑ Predominant rescue medication is ***NOT*** an opioid
- ❑ **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 detrussor overactivity and/or detrusor sphincter dyssynergia**
- ❑ **Orofacial Dyskinesia**

(continued on next page)

- ❑ **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 adenoreceptor agonist ***(will require PA)***; or
    - ❑ 1 anticholinergic agent and 1 alpha blocker and 1 β-3 adenoreceptor 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~~; **1/23/2018**;