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 1-844-723-2094**. 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) (Chronic Migraine Headache Prophylaxis)

DRUG INFORMATON: Complete information below or authorization will be delayed.

Drug 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 FOR CHRONIC MIGRAINE HEADACHE PROPHYLAXIS:
All boxes below **MUST** be checked to ensure authorization will **NOT** be delayed. Medical notes/charts **MUST** be included with this request.

- ❑ Patients must have met **ALL** the following criteria:
  - ❑ Headaches ≥ 15 days/month
  - ❑ Headaches last ≥ 4 hours/day
  - ❑ Trial and failure **to at least 3 migraine prophylaxis drugs of different classes within the last 12 months (PREVIOUS THERAPIES WILL BE VERIFIED THROUGH PHARMACY PAID CLAIMS OR SUBMITTED CHART NOTES)**
    - ❑ Anticonvulsants (divalproex, valproate, topiramate)
    - ❑ Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
    - ❑ Antidepressants (amitriptyline, venlafaxine)
  - ❑ Predominant rescue medication is **NOT** an opioid

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

Medication being provided by (check applicable box below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

(**Continued on next page; signature page MUST be attached with this request form**)

(Signature page MUST be included with request form)

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**: 7/19/2018
REVISED/UPDATED: 9/28/2018