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. **If information provided is NOT complete, correct, or legible, authorization will be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Botulinum Toxin Injections®, Type A

Drug Requested: **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 - CHRONIC MIGRAINE HEADACHE PROPHYLAXIS: Check below **ALL** that apply. **ALL** criteria must be met for approval. **ALL** documentation, including lab results and/or chart notes (if required), **must** be provided or request will be denied.

- ❑ 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; (Reformatted) 3/15/2019