# 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**.

## Botulinum Toxin Injections®, Type A (Medical)

| **Drug Requested - check applicable drug below:** | |
|---|---|
| ❑ **Botox®** (onabotulinumtoxinA) **(J0585)** | ❑ **Xeomin®** (incobotulinumtoxinA) **(J0588)** |

**DRUG INFORMATON:** Complete all information below or authorization 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 box(es) **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

***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**

❑ **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 detrusor overactivity and/or detrusor sphincter dyssynergia**
- ❑ **Orofacial Dyskinesia**
- ❑ **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 - PropriumRx**

***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~~; ~~7/24/2017~~; **9/29/2018**