

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) - Hyperhidrosis

DRUG INFORMATION. Complete information below. Authorization process will be delay if not completed.

Drug From/Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

- Max quantity limits: 400 units in a 3-month period
- **Cosmetic indications are excluded.**

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

CLINICAL CRITERIA: Check one diagnosis. Appropriate lines **MUST** be checked to qualify. Incomplete information will delay authorization process.

- Primary Axillary Hyperhidrosis** as defined by having:
 - Visible, excessive sweating for at least six (6) months, **PLUS** two (2) of the following:
 - Bilateral, symmetric sweating
 - Impairment of daily activities
 - At least one episode per week
 - Onset before 25 years of age
 - Positive family history
 - Cessation of focal sweating during sleep
 - Patients must have met **ALL** the following criteria:
 - Adequate trial and failure of topical antiperspirants (i.e. aluminum chloride hexahydrate 20% such as Certain Dri® [OTC] , Drysol®, Hypercare®, Xerac® AC [OTC])
 - Adequate trial and failure of at least one (1) systemic anticholinergic drug (glypyrrolate, oxybutynin, clonidine) verified by claims data from the past six (6) months.
- Palmoplantar Hyperhidrosis** as defined by:
 - Patients must have met **ALL** the following criteria:
 - Adequate trial and failure of topical antiperspirants (i.e. aluminum chloride hexahydrate 20% such as Certain Dri® [OTC], Drysol®, Hypercare®, Xerac® AC [OTC])
 - Adequate trial and failure of at iontophoresis

(continued on next page)

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:** 8/15/2015;

REVISED/UPDATED: 11/20/2015; 12/29/2015; 1/29/2016; 8/17/2016; 9/22/2016; 12/11/2016; **7/24/2017**;