# 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)**

***{Upper Limb Spasticity (ULS) & Lower Limb Spasticity (LLS)}***

***DRUG INFORMATION: Complete information below. If incomplete, authorization process 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*: *Check one diagnosis below. All appropriate lines must be checked to qualify or authorization will be delayed.***

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

- ❑ **Single Arm Upper Limb Spasticity**
  **OR**
  - ❑ **Anterior Arm**
    - ❑ Biceps Brachii (100-200units)
    - ❑ Flexor carpi radialis (12.5-50units)
    - ❑ Flexor Digitorum profundus [hidden] (30-50 units)
    - ❑ Flexor pollicis longus (20 units)
    - ❑ Flexor digitorum superficialis (30-50 units)
    - ❑ Adductor pollicis (20 units)

- ❑ **Both Arms Upper Limb Spasticity**
  - ❑ **Posterior Arm**
    - ❑ Biceps brachii (100-200 units)
    - ❑ Flexor carpi radialis (12.5 -50 units)
    - ❑ Adductor Pollicis (20 units)
  - ❑ **Lower Limb Spasticity**
    - ❑ Ankle and toe muscles (300-400units)

***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 charts.***

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; 3/11/16; 3/31/2016; 5/4/2016; 8/17/2016;~~ 9/22/2016; ~~12/11/2016;~~ **7/24/2017**