

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.**

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

CLINICAL CRITERIA: Check one diagnosis below. All appropriate lines **must** be checked to qualify or authorization will be delayed.

Single Arm Upper Limb Spasticity

OR

Both Arms Upper Limb Spasticity

Anterior Arm

- Biceps Brachii (100-200 units divided in 4 sites)
- Flexor Carpi Radialis (12.5 - 50 units)
- Flexor Carpi Ulnaris (12.5 – 50 units)
- Flexor Pollicis Longus (20 units)

Posterior Arm

- Flexor Digitorum Profundus (30-50 units)
- Flexor Digitorum Sublimis (30-50 units)

Adductor Pollicis (20 units)

Lower Limb Spasticity (300 – 400 units divided among 5 muscles)

- Gastrocnemius Medial Head (75 units)
- Gastrocnemius Lateral Head (75 units)
- Soleus (75 units)
- Tibialis Posterior (75 units)
- Flexor Halluces Longus (50 units)
- Flexor Digitorum Longus (50 units)

(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 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; 9/20/2016; 11/16/2016; 12/12/2016; 7/24/2017; 12/12/2017