Botox

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____kg

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office*

Drug Information:

Strength/Measure _____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) _____ *Route of administration* _____
Dosing frequency _____

What is the ICD-10 code? _____

Exception Criteria:

A. Is this a request for the treatment of any of the following: A) Cervical dystonia in an adult, B) Spasticity?
❑Yes, Cervical dystonia in an adult
❑Yes, Spasticity
❑No, none of the above, *skip to Site of Service Questions*

B. *The preferred product for your patient's health plan is Dysport.*
Can the patient's treatment be switched to the preferred product?
❑Yes, *Please obtain Form for preferred product and submit for corresponding PA*
❑No

Send completed form to: Priority Partners Fax: 1-866-212-4756

 JHHC SOC MR Botox SGM 2247-A – 01/2024.

C. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred product (Dysport)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).***
❑ Yes ❑ No

Site of Service Questions:

A. Indicate the site of service requested:
❑ Ambulatory Surgical (POS Code 24), *Skip to Clinical Criteria Questions*
❑ Home (POS Code 12), *Skip to Clinical Criteria Questions*
❑ Off Campus Outpatient Hospital (POS Code 19)
❑ On Campus Outpatient Hospital (POS Code 22)
❑ Office (POS Code 11*), Skip to Clinical Criteria Questions*

B. Is the patient less than 18 years of age?
❑ Yes, *skip to Clinical Criteria Questions*
❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg, acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation***.
❑ Yes ❑ No

Clinical Criteria Questions:

1. Is therapy prescribed for cosmetic purposes (e.g., treatment of wrinkles or uncorrected congenital strabismus and no binocular fusion)?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. What is the diagnosis?

❒ Blepharospasm, *Continue to 67*

❒ Cervical dystonia (e.g., torticollis), *Continue to 63*

❒ Chronic migraine prophylaxis, *Continue to 3*

❒ Overactive bladder with urinary incontinence, *Continue to 19*

❒ Primary axillary, palmar, or gustatory (Frey's syndrome) hyperhidrosis, *Continue to 25*

❒ Strabismus, *Continue to 31*

❒ Upper limb spasticity, *Continue to 60*

❒ Lower limb spasticity, *Continue to 60*
❒ Urinary incontinence associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis), *Continue to 35*

❒ Achalasia, *Continue to 39*

❒ Chronic anal fissures, *Continue to 41*

❒ Essential tremor, *Continue to 70*

❒ Excessive salivation (chronic sialorrhea, ptyalism), *Continue to 43*

❒ Hemifacial spasm, *Continue to 71*

❒ Spasmodic dysphonia (laryngeal dystonia), *Continue to 72*

❒ Oromandibular dystonia, *Continue to 73*

❒ Myofascial pain syndrome, *Continue to 45*

❒ Focal hand dystonia, *Continue to 74*

❒ Facial myokymia, *Continue to 75*

❒ Hirschsprung disease with internal sphincter achalasia, *Continue to 47*

❒ Orofacial tardive dyskinesia, *Continue to 50*

❒ Painful bruxism, *Continue to 52*

❒ Palatal myoclonus, *Continue to 55*

❒ First bite syndrome, *Continue to 58*

❒ Other, please specify. _____, *No further questions*

3. Is this request for continuation of therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 8*

4. Is the requested medication prescribed by or in consultation with a neurologist, pain specialist, or physiatrist?

❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. What is the patient's age?

❒ 18 years of age or older, *Continue to 6*

❒ Less than 18 years of age, *Continue to 6*

6. Will dosing exceed a cumulative dose of 400 units every 84 days?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Has the patient achieved or maintained a reduction in monthly headache frequency since starting therapy with the requested drug?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. Prior to initiating therapy, how many days per month does (did) the patient experience headaches?

_____ days, *Continue to 9*

9. Do (did) the patient's headaches last 4 hours or longer on at least 8 days per month?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Has the patient completed an adequate trial of 2 oral migraine preventative therapies coming from at least 2 of the following classes: a) Antidepressants (e.g., amitriptyline, venlafaxine), b) Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), c) Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)?
❒ Yes, *Continue to 12*
❒ No, *Continue to 11*

11. Does the patient have a contraindication to any of the following classes: a) Antidepressants (e.g., amitriptyline, venlafaxine), b) Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), c) Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

12. How many of the following classes has the patient had an adequate trial: a) Antidepressants (e.g., amitriptyline, venlafaxine), b) Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), c) Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)?

❒ One class, *Continue to 15*

❒ Two or more classes, *Continue to 14*

13. How many of the following classes does the patient have a contraindication to: a) Antidepressants (e.g., amitriptyline, venlafaxine), b) Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), c) Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)?

❒ One class, *Continue to 15*

❒ Two or more classes, *Continue to 15*

14. How many days was the trial of each medication?

_____ days, *Continue to 15*

15. Does the patient have signs and symptoms consistent with chronic migraine criteria as defined by the International Headache Society (IHS)?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Is the requested medication prescribed by or in consultation with a neurologist, pain specialist, or physiatrist?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. What is the patient's age?

❒ 18 years of age or older, *Continue to 18*

❒ Less than 18 years of age, *Continue to 18*

18. Will dosing exceed a cumulative dose of 400 units every 84 days?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

19. Prior to initiating therapy with the requested drug - along with urinary incontinence, does (did) the patient experience urgency and frequency?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Has the patient tried and failed behavioral therapy?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Has the patient had an inadequate response or experienced intolerance to at least two agents from either of the following classes: a) Anticholinergic drugs (e.g., Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin]), b) Beta-3 adrenergic agonist (e.g., Myrbetriq [mirabegron], Gemtesa [vibegron])?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Is the requested medication prescribed by or in consultation with a neurologist, urologist, or gynecologist?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. What is the patient's age?

❒ 18 years of age or older, *Continue to 24*

❒ Less than 18 years of age, *Continue to 24*

24. Will dosing exceed a cumulative dose of 400 units every 84 days?
❒ Yes, *Continue to 79*
❒ No, *Continue to 79*

25. Has significant disruption of professional and/or social life occurred because of excessive sweating?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Has the patient tried topical aluminum chloride or other extra-strength antiperspirants?
❒ Yes, *Continue to 27*
❒ No, *Continue to 28*

27. Was the topical aluminum chloride or other extra-strength antiperspirant ineffective or result in a severe rash?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Is the requested medication prescribed by or in consultation with a neurologist, internist, or dermatologist?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. What is the patient's age?

❒ 18 years of age or older, *Continue to 30*

❒ Less than 18 years of age, *Continue to 30*

30. Will dosing exceed a cumulative dose of 400 units every 84 days?
❒ Yes, *Continue to 79*
❒ No, *Continue to 79*

31. Is interference with the patient's normal visual system likely to occur? Note: Strabismus repair is considered cosmetic in adults with uncorrected congenital strabismus and no binocular fusion.
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

32. Is the patient likely to have spontaneous recovery?
❒ Yes, *Continue to 33*
❒ No, *Continue to 33*

33. Is the requested drug prescribed by or in consultation with a neurologist or ophthalmologist?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. Is the patient 12 years of age or older?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

35. Has the patient tried and failed behavioral therapy?
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. Has the patient had an inadequate response or experienced intolerance to one agent from either of the following classes: a) Anticholinergic drugs (e.g., Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin]), b) Beta-3 adrenergic agonist (e.g., Myrbetriq [mirabegron]?
❒ Yes, *Continue to 37*
❒ No, *Continue to 37*

37. Is the requested medication prescribed by or in consultation with a neurologist, urologist, or gynecologist?
❒ Yes, *Continue to 38*
❒ No, *Continue to 38*

38. Is the patient 5 years of age or older?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

39. Has the patient tried and failed or is a poor candidate for conventional therapy such as pneumatic dilation and surgical myotomy?
❒ Yes, *Continue to 40*
❒ No, *Continue to 40*

40. Is the requested medication prescribed by or in consultation with a gastroenterologist, proctologist, or colorectal surgeon?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

41. Has the patient failed to respond to first line therapy for chronic anal fissures such as topical calcium channel blockers or topical nitrates?
❒ Yes, *Continue to 42*
❒ No, *Continue to 42*

42. Is the requested drug prescribed by or in consultation with a gastroenterologist, proctologist, or colorectal surgeon?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

43. Is the patient refractory to pharmacotherapy (e.g., anticholinergics)?

❒ Yes, *Continue to 44*
❒ No, *Continue to 44*

44. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

45. Has the patient tried and failed all of the following for the treatment of myofascial pain syndrome: a) Physical therapy, b) Injection of local anesthetics into trigger points, c) Injection of corticosteroids into trigger points?

❒ No, *Continue to 46*

❒ Yes, *Continue to 46*

46. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

47. Has the patient undergone an endorectal pull through to treat Hirschsprung disease with internal sphincter achalasia?
❒ Yes, *Continue to 48*
❒ No, *Continue to 48*

48. Is the patient refractory to laxative therapy?
❒ Yes, *Continue to 49*
❒ No, *Continue to 49*

49. Is the requested medication prescribed by or in consultation with a gastroenterologist, proctologist, or colorectal surgeon?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

50. Has the patient tried and failed conventional therapies for orofacial tardive dyskinesia (e.g., benzodiazepines, clozapine, or tetrabenazine)?
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Is the requested medication prescribed by or in consultation with a neurologist, pain specialist, or physiatrist?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

52. Did the patient try and have an inadequate response to a night guard?
❒ Yes, *Continue to 53*
❒ No, *Continue to 53*

53. Did the patient have an inadequate response to pharmacotherapy such as diazepam?

❒ Yes, *Continue to 54*
❒ No, *Continue to 54*

54. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

55. Prior to initiating therapy with the requested drug, does (did) the patient have disabling symptoms (for example, intrusive clicking tinnitus)?
❒ Yes, *Continue to 56*
❒ No, *Continue to 56*

56. Did the patient have an inadequate response to clonazepam, lamotrigine, carbamazepine, or valproate?
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

57. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

58. Has the patient failed to experience relief from analgesics, antidepressants, or anticonvulsants?
❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. Is the requested medication prescribed by or in consultation with a neurologist or oncologist?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

60. Does the patient have a primary diagnosis of upper or lower limb spasticity or as a symptom of a condition causing limb spasticity (including focal spasticity or equinus gait due to cerebral palsy)?
❒ Yes, *Continue to 61*
❒ No, *Continue to 61*

61. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?
❒ Yes, *Continue to 62*
❒ No, *Continue to 62*

62. Is the patient 2 years of age or older?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

63. Prior to initiating therapy with the requested drug, was/is there abnormal placement of the head with limited range of motion in the neck?

❒ Yes, *Continue to 64*
❒ No, *Continue to 64*

64. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?
❒ Yes, *Continue to 65*
❒ No, *Continue to 65*

65. What is the patient's age?

❒ 18 years of age or older, *Continue to 66*

❒ Less than 18 years of age, *Continue to 66*

66. Will dosing exceed a cumulative dose of 400 units every 84 days?
❒ Yes, *Continue to 79*
❒ No, *Continue to 79*

67. Has the patient been diagnosed with blepharospasm, including blepharospasm associated with dystonia, benign essential blepharospasm or VII nerve disorder?
❒ Yes, *Continue to 68*
❒ No, *Continue to 68*

68. Is the requested medication prescribed by or in consultation with a neurologist or ophthalmologist?
❒ Yes, *Continue to 69*
❒ No, *Continue to 69*

69. Is the patient 12 years of age or older?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

70. Is the requested medication prescribed by or in consultation with a neurologist, pain specialist, or physiatrist?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

71. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

72. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

73. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?

❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

74. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

75. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

76. What is the patient's age?

❒ 18 years of age or older, *Continue to 77*

❒ Less than 18 years of age, *Continue to 78*

77. Will dosing exceed a cumulative dose of 400 units every 84 days?
❒ Yes, *Continue to 79*
❒ No, *Continue to 79*

78. Will the dosing exceed the lessor of 10 units/kg or 340 units every 84 days?
❒ Yes, *Continue to 79*
❒ No, *Continue to 79*

79. Is this request for continuation of therapy?
❒ Yes, *Continue to 80*
❒ No, *No Further Questions*

80. Was the requested drug effective for treating the diagnosis or condition?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756