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*

Drug Information:

*Strength/Measure*_____ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

*Directions(sig)*_____ *Route of administration*_____

*Dosing frequency*_____

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

Exception Criteria:

A. Is this a request for the treatment of any of the following conditions?
   - Cervical dystonia in an adult member
   - Spasticity

   ❑Yes ❑No, *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

C. Has the patient had a documented inadequate response to treatment with the preferred product (Dysport)? **Action Required:** ***If 'Yes', attach supporting chart note(s).*** ❑ Yes, *skip to Site of Service Questions* ❑ No

D. Has the patient experienced a documented intolerable adverse event 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:
   ❑ On Campus Outpatient Hospital (22)
   ❑ Off Campus Outpatient Hospital (19)
   ❑ Home (12), *skip to Criteria Questions*
   ❑ Office (11), *skip to Criteria Questions*
   ❑ Ambulatory Surgical Center (24), *skip to 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. What is the diagnosis?
   - ❑ Cervical dystonia (e.g., torticollis)
   - ❑ First bite syndrome
   - ❑ Chronic migraine prophylaxis
   - ❑ Strabismus
   - ❑ Chronic anal fissures
   - ❑ Excessive salivation (chronic sialorrhea, ptyalism)
   - ❑ Spasmodic dysphonia (laryngeal dystonia)
   - ❑ Myofascial pain syndrome
   - ❑ Facial myokymia
   - ❑ Painful bruxism
   - ❑ Upper limb spasticity
   - ❑ Lower limb spasticity
   - ❑ Overactive bladder with urinary incontinence
   - ❑ Achalasia
   - ❑ Essential tremor
   - ❑ Hemifacial spasm
   - ❑ Oromandibular dystonia
   - ❑ Focal hand dystonia
   - ❑ Orofacial tardive dyskinesia
   - ❑ Palatal myoclonus
   - ❑ Hirschsprung disease with internal sphincter achalasia
   - ❑ Blepharospasm, including blepharospasm associated with dystonia and benign essential blepharospasm
   - ❑ Primary axillary, palmar, or gustatory (Frey's syndrome) hyperhidrosis
   - ❑ Urinary incontinence associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis)
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Is therapy prescribed for cosmetic purposes (e.g., treatment of wrinkles or uncorrected congenital strabismus and no binocular fusion)? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Chronic Migraine Prophylaxis

4. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #6*

5. Has the patient achieved or maintained a reduction in monthly headache frequency since starting therapy with Botox? ❑ Yes ❑ No *No further questions*

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

7. Do (did) the patient's headaches last 4 hours or longer on at least 8 days per month? ❑ Yes ❑ No

8. Has the patient completed an adequate trial of 3 oral migraine preventative therapies coming from at least 2 of the following classes? *If Yes, skip to #11* ❑ Yes ❑ No
   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)

9. Does the patient have a contraindication to any of the following classes?
   Indicate ALL that apply and, if all three, skip to #12.
   - ❑ Antidepressants (e.g., amitriptyline, venlafaxine)
   - ❑ Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium)
   - ❑ Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)
   - ❑ None of the above

10. Has the patient tried oral migraine preventative therapy from one of the following classes?
    - ❑ Antidepressants (e.g., amitriptyline, venlafaxine)
    - ❑ Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium)
    - ❑ Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)
    - ❑ None of the above

11. How many days was the trial of each medication? _____

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12. Does the patient have signs and symptoms consistent with chronic migraine criteria as defined by the International Headache Society (IHS)? ❑ Yes ❑ No

Section B: Cervical Dystonia

13. Is the patient an adult? ❑ Yes ❑ No

14. Prior to initiating therapy with Botox, was/is there abnormal placement of the head with limited range of motion in the neck? ❑ Yes ❑ No

Section C: Overactive Bladder with Urinary Incontinence

15. Prior to initiating therapy with Botox - along with urinary incontinence, does (did) the patient experience urgency and frequency? ❑ Yes ❑ No

16. Has the patient tried and failed behavioral therapy? ❑ Yes ❑ No

17. Has the patient had an inadequate response or experienced intolerance to at least two anticholinergic medications (examples: Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin])? ❑ Yes ❑ No

Section D: Primary Axillary, Palmar, or Gustatory (Frey's Syndrome) Hyperhidrosis

18. Has significant disruption of professional and/or social life occurred because of excessive sweating? ❑ Yes ❑ No

19. Has the patient tried topical aluminum chloride or other extra-strength antiperspirants? ❑ Yes ❑ No

20. Was the topical aluminum chloride or other extra-strength antiperspirant ineffective or result in a severe rash? ❑ Yes ❑ No

21. Is the patient unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anticholinergics, beta-blockers, or benzodiazepines)? ❑ Yes ❑ No

Section E: Strabismus

22. Is interference with the patient's normal visual system likely to occur? ❑ Yes ❑ No

23. Is the patient likely to have spontaneous recovery? ❑ Yes ❑ No

Section F: Urinary Incontinence Associated with a Neurologic Condition

24. Has the patient tried and failed behavioral therapy? ❑ Yes ❑ No

25. Has the patient had an inadequate response or experienced intolerance to an anticholinergic medication (examples: Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin])? ❑ Yes ❑ No

Section G: Achalasia

26. Has the patient tried and failed conventional therapy such as pneumatic dilation and surgical myotomy? ❑ Yes ❑ No

Section H: Chronic Anal Fissures

27. Has the patient failed to respond to first line therapy for chronic anal fissures such as topical calcium channel blockers or topical nitrates? ❑ Yes ❑ No

Section I: Excessive Salivation

28. Is the patient refractory to pharmacotherapy (for example, anticholinergics)? ❑ Yes ❑ No

Section J: Myofascial Pain Syndrome

29. How many of the following treatments has the patient tried and failed for myofascial pain syndrome? _____
    a) Physical therapy
    b) Injection of local anesthetics into trigger points
    c) Injection of corticosteroids into trigger points

Section K: Hirschsprung Disease with Internal Sphincter Achalasia

30. Has the patient undergone an endorectal pull through to treat the Hirschprung disease with internal sphincter achalasia? ❑ Yes ❑ No

31. Is the patient refractory to laxative therapy? ❑ Yes ❑ No

Section L: Orofacial Tardive Dyskinesia

32. Has the patient tried and failed conventional therapies for orofacial tardive dyskinesia (examples: benzodiazepines, clozapine, or tetrabenazine)? ❑ Yes ❑ No

Section M: Painful Bruxism

33. Did the patient try and have an inadequate response to a night guard? ❑ Yes ❑ No

34. Did the patient have an inadequate response to pharmacotherapy such as diazepam? ❑ Yes ❑ No

Section N: Palatal Myoclonus

35. Prior to initiating therapy with Botox - does (did) the patient have disabling symptoms (for example, intrusive clicking tinnitus)? ❑ Yes ❑ No

36. Did the patient have an inadequate response to clonazepam, lamotrigine, carbamazepine, or valproate? ❑ Yes ❑ No

Section O: First Bite Syndrome

37. Has the patient failed to experience relief from analgesics, antidepressants, or anticonvulsants? ❑ Yes ❑ No

Section P: Upper and Lower Limb Spasticity

38. Is the spasticity either the primary diagnosis or a symptom of a condition causing limb spasticity? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

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

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