Dysport

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:** ____________________

<u>Referring</u> Provider Info: ❑ **Same as Requesting Provider**
Name: ____ **NPI#:** ________________________________
Fax: _________________________ **Phone:** ______________________

<u>Rendering</u> 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.

<u>Required Demographic Information:</u>

Patient Weight: __________________________*kg*

*Patient Height:*___________________________*cm*

<u>Drug Information:</u>

*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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. JHHC SOC Dysport SGM – 07/2021.

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)
❑ Upper limb spasticity
❑ Lower limb spasticity
❑ Blepharospasm, including blepharospasm associated with dystonia and benign essential blepharospasm
❑ Hemifacial spasm
❑ Chronic anal fissures
❑ Excessive salivation (chronic sialorrhea)
❑ Primary axillary hyperhidrosis
❑ Other ____

2. What is the ICD-10 code? _____________

3. Is therapy prescribed for cosmetic purposes (e.g., treatment of wrinkles)? ❑ Yes ❑ No

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

Section A: Cervical Dystonia

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

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Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

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

Section B: Chronic Anal Fissures

6. 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 C: Excessive Salivation

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

Section D: Primary Axillary Hyperhidrosis

8. Has significant disruption of professional and/or social life occurred because of excessive sweating? ❑ Yes ❑ No
9. Has the patient tried topical aluminum chloride or other extra-strength antiperspirant? ❑ Yes ❑ No
10. Was the topical aluminum chloride or other extra-strength antiperspirant ineffective or result in a severe rash? ❑ Yes ❑ No
11. Is the patient unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anticholinergics, beta-blockers, or benzodiazepines)? ❑ Yes ❑ No

Section E: Upper and Lower Limb Spasticity

12. Is the spasticity 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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