



Xeomin

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:** _____

Referring 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

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 MR Xeomin SGM- 07/2021.

Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076

Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com

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:
- | | |
|--|--|
| <input type="checkbox"/> On Campus Outpatient Hospital (22) | <input type="checkbox"/> Off Campus Outpatient Hospital (19) |
| <input type="checkbox"/> Home (12), skip to Criteria Questions | <input type="checkbox"/> Office (11), skip to Criteria Questions |
| <input type="checkbox"/> 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 ICD-10 code? _____

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 MR Xeomin SGM- 07/2021.

Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076

Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com

2. Is therapy prescribed for cosmetic purposes (eg, treatment of wrinkles)? Yes No
3. What is the diagnosis?
 - Upper limb spasticity *Skip to #7*
 - Blepharospasm, including blepharospasm associated with dystonia and benign essential blepharospasm *No further questions*
 - Cervical dystonia (e.g., torticollis)
 - Excessive salivation (chronic sialorrhea) *Skip to #6*
 - Other _____
4. Is the patient an adult? Yes No
5. Prior to initiating therapy with Xeomin, was/is there abnormal placement of the head with limited range of motion in the neck? Yes No *No further questions*
6. Is the patient refractory to pharmacotherapy (for example, anticholinergics)?
 - Yes No *No Further Questions*
7. Is the spasticity a 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)

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 MR Xeomin SGM- 07/2021.

Priority Partners • 7231 Parkway Drive Suite 100 • Hanover, MD 21076

Phone: 888-819-1043 • Fax: 1-866-212-4756 • www.jhhc.com