

# SENTARA COMMUNITY PLAN (MEDICAID)

## 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 1-844-305-2331. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If information provided is not complete, correct, or legible, authorization can be delayed.

### Botulinum Toxin Injections<sup>®</sup>, Type A

**Drug Requested:** Botox<sup>®</sup> (onabotulinumtoxinA) (J0585) (Medical)  
(Chronic Migraine Headache Prophylaxis)

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

Member Name: \_\_\_\_\_

Member Sentara #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight: \_\_\_\_\_ Date: \_\_\_\_\_

- **Max quantity limits:** 155 units once every 12 weeks
- **Cosmetic indications are EXCLUDED**

**NOTE:** In treating adult patients for one or more indications, the maximum cumulative dose should not exceed 400 units, in a 3-month interval. In pediatric patients, the total dose should not exceed the lower of 10 units/kg body weight or 340 units, in a 3-month interval.

**Sentara considers the use of concomitant therapy with CGRP antagonists and Botox<sup>®</sup> to be experimental and investigational. Safety and efficacy of these combinations has not been established and will not be permitted. In the event a member has an active Botox<sup>®</sup> authorization on file, all subsequent requests injectable or oral CGRP antagonists indicated for migraine prevention will not be approved.**

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- ☐ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

**CLINICAL CRITERIA:** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

**Diagnosis: Chronic Migraine Headache Prophylaxis**

**Initial Authorization Approval: 12 months**

- ☐ Has the member been approved for Botox previously through the Sentara pharmacy department?  
☐ Yes ☐ No
- ☐ Member must be  $\geq 18$  years of age
- ☐ Member experiences  $\geq 15$  headache days per month
- ☐ Member experiences headaches which last  $\geq 4$  hours per day
- ☐ Member must have failed a **2-month** trial of at least one medication from **TWO (2)** different migraine prophylactic classes supported by American Headache Society/American Academy of Neurology treatment guidelines 2012/2015/2021, Level A and B evidence; ICSI 2013, high quality evidence (**verified by pharmacy paid claims or submitted chart notes**):
- ☐ Anticonvulsants (divalproex, valproate, topiramate)
- ☐ Beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
- ☐ Antidepressants (amitriptyline, venlafaxine)
- ☐ Injectable CGRP inhibitors (Aimovig<sup>®</sup>, Emgality<sup>®</sup>, Ajovy<sup>®</sup>) or oral CGRP inhibitors indicated for migraine prevention (Qulipta<sup>™</sup>, Nurtec ODT<sup>™</sup>) **\*requires prior authorization\***
- ☐ Member has been evaluated for medication overuse headache (MOH) (defined as headaches occurring greater than or equal to 15 days per month. It develops as a consequence of regular overuse of acute or symptomatic headache medication for more than 3 months)
- ☐ Treatment will include a plan to taper off the offending medication if MOH is diagnosed

**Reauthorization Approval: 12 months.** Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member has experienced a positive response to therapy, demonstrated by a reduction in headache frequency
- ☐ Use of acute migraine medications (e.g., NSAIDs, triptans) has decreased since the start of Botox<sup>®</sup>
- ☐ Member continues to be monitored for medication overuse headache (MOH)
- ☐ Botox<sup>®</sup> will **NOT** be used in combination with another CGRP inhibitor indicated for migraine prevention.

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Medication being provided by (check box below that applies):

☐ Physician's office                      OR                      ☐ Specialty Pharmacy – PropriumRx

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

***\*\*Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.\*\****

***\*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.\****