SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Botulinum Toxin Injections®, Type A

Drug Requested: Botox® (onabotulinumtoxinA) **– Hyperhidrosis (Pharmacy)**

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:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/ Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

- **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.

Recommended Dosing: 50 units per axilla

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.

Length of Authorization: 1 year

(Continued on next page)

- ❑ Has the member been approved for Botox previously through the Sentara medical department?
  - ❑ Yes
  - ❑ No
- ❑ Member has a diagnosis of **Primary Axillary Hyperhidrosis as defined by having:**
  - ❑ Visible, excessive sweating for **at least six (6) months, AND** at least **two (2)** of the following **(submit chart notes; check all that apply**):
    - ❑ Bilateral, symmetric sweating
    - ❑ Impairment of daily activities
    - ❑ At least one episode per week
    - ❑ Onset before 25 years of age
    - ❑ Positive family history
    - ❑ Cessation of focal sweating during sleep
- ❑ Member must have adequate trial and failure of **BOTH** the following therapies **within the past six (6) months (verified by chart notes and/or pharmacy paid claims):**
  - ❑ Topical prescription strength antiperspirant e.g., DrySol (aluminum chloride hexahydrate 20%)
  - ❑ Systemic anticholinergic drug (e.g., glycopyrrolate, oxybutynin, clonidine)

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – Proprium Rx**

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****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.****

***Approved by Pharmacy and Therapeutics Committee**: 8/1/2017
REVISED/UPDATED/REFORMATTED: ~~8/1//2017; 8/17/2018; 10/8/2018; 2/4/2019; 7/22/2019; 10/15/2019; 10/16/2020; 7/10/2023;~~ **10/15/2024**