# 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®, Type A

**Drug Requested: Botox®** (onabotulinumtoxinA) **(J0585) – Hyperhidrosis (Medical)**

**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 Form/Strength:** _____

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

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

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

- ❑ 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.

- **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

**(Continued on next page)**

**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**

- ❑ Has the member been approved for Botox previously through the Sentara pharmacy 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**

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.****



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**(Reformatted)** ~~10/16/2020; 7/10/2023; 10/04/2023;~~ **10/18/2024**