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 (Pharmacy)

Drug Requested: Botox® (onabotulinumtoxinA)
(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:** _____

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:** _____

- **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.

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.

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Diagnosis: Chronic Migraine Headache Prophylaxis

Initial Authorization Approval: 12 months

- ❑ Has the member been approved for Botox previously through the Sentara Health Plan medical department? ❑ Yes ❑ No
  - ❑ Member must be ≥ 18 years of age
  - ❑ Member experiences ≥ 15 headache days per month
  - ❑ Member experiences headaches which last ≥ 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®, Emgality®, Ajovy®) or oral CGRP inhibitors indicated for migraine prevention (Qulipta™, Nurtec ODT™) *** 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®
- ❑ Member continues to be monitored for medication overuse headache (MOH)

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

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

*****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**: ~~7/19/2018~~; **1/14/2022**
REVISED/UPDATED/REFORMATTED: ~~9/28/2018; 3/15/2019; 7/1/2019; 7/11/2019; 9/16/2019; 1/21/2020; 11/8/2021; 11/17/2021; 1/14/2022; 2/24/2022; 3/23/2022;07/10/2023; 11/8/2023; 12/19/2023;~~ **9/6/2024**