OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(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 1-804-799-5118.** 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 (Medical)

Drug Requested: (check applicable drug below)

❑ **Botox®** (onabotulinumtoxinA) **(J0585)**	❑ **Xeomin®** (incobotulinumtoxinA) **(J0588)**

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

Member Name: _____

Member Optima #: _____ **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:** _____

- **Max quantity limits:** 400 units in a 3-month period
- **Cosmetic indications are EXCLUDED**

❑ 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.

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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.

- ❑ **Achalasia, Primary idiopathic esophageal**
  - ❑ Member failed or had a clinically significant adverse reaction to conventional therapy (nitrates or calcium channel blockers)

    OR
  - ❑ Member ineligible for surgical treatment due to advance age or multiple co-morbidities (poor surgical risk)

    OR
  - ❑ Member is at high risk of complications of pneumatic dilation or surgical myotome

    OR
  - ❑ Failure of prior myotomy or dilation

    OR
  - ❑ Member has an epiphrenic diverticulum or hiatal hernia, both of which increase the risk of dilation induced perforation

- ❑ **Achalasia, Internal anal sphincter (IAS)**
  - ❑ Member has not responded to treatment with laxatives

    AND
  - ❑ Member has not responded to or is not a candidate for anal sphincter myectomy

- ❑ **Anal Fissure – Chronic**
  - ❑ Member failed (at least 60 days) topical nitroglycerin or topical calcium channel blocker
- ❑ **Blepharospasm**
- ❑ **Cerebral Palsy – Dynamic Contracture**
- ❑ **Cerebral Palsy** – **Spasticity** (including diplegia, hemiplegia, paraplegia, or quadriplegia)
- ❑ **Cervical Dystonia** (spasmodic torticollis) and **Mixed Cervical Dystonia**
- ❑ **CVA-related spasticity** within 1 year of onset
- ❑ **Drooling in Parkinson's disease**
- ❑ **Essential hand tremor in patients who fail oral agents**
- ❑ **Hand Dystonia**
- ❑ **Hemifacial spasm**
- ❑ **Hirschsprung's Disease**
- ❑ **Laryngeal Dysphonia – Spastic**
- ❑ **Laryngeal Dystonia** (adductor spasmodic dysphonia)

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- ❑ **Laryngeal Spasm**
- ❑ **Motor tics**
- ❑ **Neurogenic detrusor overactivity (NDO) and/or detrusor sphincter dyssynergia:**
  - ❑ Member has diagnosis of incontinence due to NDO or detrusor sphincter dyssynergia associated with a neurologic condition (e.g., multiple sclerosis, spinal cord injury, brain injury) that has been confirmed by urodynamic testing **(submit documentation of diagnosis)**
  - ❑ **For members aged 5-17 years:** Member has had a 30 day trial and failure of oxybutynin (oral or intravesical use) and one other oral systemic medication from the following classes: anticholinergics or beta-3 antagonists **(Must submit chart notes documenting therapy failures)**
  - ❑ **For members aged 17 years and older:** Member has had a 30 day trial and failure of two oral systemic medications from the following classes: anticholinergics or beta-3 antagonists **(Must submit chart notes documenting therapy failures)**
- ❑ **Orofacial Dyskinesia**
- ❑ **Overactive Bladder** – Members must have met all the following criteria:
  - ❑ Diagnosis of incontinence
  - ❑ Symptoms of urge incontinence, urgency, and frequency (experienced at least 3 urinary incontinence episodes and at least 24 micturitions in 3 days)
  - ❑ 8–12-week trial and failure of behavioral therapy (e.g., bladder training, control strategies, pelvic floor muscle training, fluid management)
  - ❑ Failed or inadequate response to anticholinergic therapy within the last 9 months (4–8-week trial per agent)
  - ❑ 2 anticholinergic agents and 1 β-3 adenoreceptor agonist (**requires PA**); **OR**
  - ❑ 1 anticholinergic agent and 1 alpha blocker and 1 β-3 adenoreceptor agonist (**requires PA**)

    Please indicate drugs used: _____
- ❑ **Strabismus** (injections done in lieu of coverage for surgery)
- ❑ **Synkinetic Eyelid Closure – VII Cranial Nerve**
- ❑ **Torticollis**

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

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

For urgent reviews: Practitioner should call Optima Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Optima'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

*****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**: ~~11/18/2010~~; 5/21/2015
REVISED/UPDATED: **7/9/2021,** 11/8/2021; ~~11/12/2021;~~ **9/19/2023;**