OPTIMA COMMUNITY 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

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

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 INFORMATON. Authorization may be delayed if incomplete.

Drug From/Strength/Quantity: _____

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

Diagnosis: _____ **ICD Code:** _____

- **Cosmetic indications are EXCLUDED.**

❑ Standard Review. In checking this box, the time frame 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.

❑ **Primary Axillary Hyperhidrosis** as defined by having:

- ❑ Visible, excessive sweating for at **least six (6) months**, **PLUS** **two** (2) of the following:
  - ❑ Bilateral, symmetric sweating
  - ❑ Impairment of daily activities

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- ❑ At least one episode per week
- ❑ Onset before 25 years of age
- ❑ Positive family history
- ❑ Cessation of focal sweating during sleep

❑ Member must have met all the following criteria:

- ❑ Adequate trial and failure of topical antiperspirants (i.e. aluminum chloride hexahydrate 20% such as Certain Dri® [OTC] , Drysol®, Hypercare®, Xerac® AC [OTC])
- ❑ Adequate trial and failure of at least one (1) systemic anticholinergic drug (glypyrrolate, oxybutynin, clonidine) verified by claims data from the past six (6) months.

❑ **Palmoplantar Hyperhidrosis** as defined by:

❑ Member must have met all the following criteria:

- ❑ Adequate trial and failure of topical antiperspirants (i.e. aluminum chloride hexahydrate 20% such as Certain Dri® [OTC], Drysol®, Hypercare®, Xerac® AC [OTC])
- ❑ Adequate trial and failure of at iontophoresis

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

❑ **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 maximum function.

Use of samples to initiate therapy does not meet step edit/pre-authorization criteria.

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