SENTARA HEALTH PLAN

PHARMACY/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 1-844-6681550**. 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 will be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Botulinum Toxin Injections®, Type A

Drug Requested: Botox® (onabotulinumtoxinA) **(J0585) (Medical)**
(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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

❑ 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.

- **Max quantity limits**: 155 units once every 12 weeks
- **Cosmetic indications are EXCLUDED.**

Sentara considers the use of concomitant therapy with CGRP antagonists and Botox® to be experimental and investigational. Safety and efficacy of these combinations has not been established and will not be permitted. In the event a member has an active Botox® authorization on file, all subsequent requests injectable or oral CGRP antagonists indicated for migraine prevention will not be approved.

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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.

Initial Authorization: 12 months

- ❑ 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 a least one medication from **TWO** different migraine prophylactic classes supported by the American Headache Society/American Academy of Neurology treatment guidelines 2012/2015/2021, Level A and B evidence; ICSI 2013, high quality evidence **(verified by chart notes or pharmacy paid claims)**:
  - ❑ 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: 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)
- ❑ Botox® will **NOT** be used in combination with another CGRP inhibitor indicated for migraine prevention

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Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____

OR

- ❑ **Specialty Pharmacy – PropriumRx**

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

***Approved by Pharmacy and Therapeutics Committee**: ~~7/19/2018; 1/14/2022;~~ **2/16/2023**
REVISED/UPDATED: ~~9/28/2018; (Reformatted) 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;~~ **3/9/2023**