SENTARA HEALTH PLANS

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 B

Drug Requested: Myobloc® (rimabotulinumtoxinB)

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:** _____

- **Cosmetic indications are EXCLUDED**

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.

❑ Member has **ONE** of the following diagnoses:

(Continued on next page)

- **Cervical Dystonia (spasmodic torticollis) and Mixed Cervical Dystonia:**
  - Initial Dose
    - **Botulinum-Naïve Patients**: 2500 units intramuscularly in divided doses among affected muscles
    - **Botulinum-Experienced Patients**: 2500-5000 units intramuscularly in divided doses among affected muscles
    - **Max total dose**: 10000 units in a 12-week period
    - **Re-treatment interval should NOT be less than 12 weeks**

- **Drooling due to neurologic diseases (i.e., ALS, Parkinson's disease, cerebral palsy, multiple sclerosis):**
  - Member has a documented diagnosis of drooling or chronic sialorrhea
  - Treatment failure with glycopyrrolate or scopolamine patches, or documentation of clinical inappropriateness of treatment with anticholinergic medications
  - **Dose**: 250-1000 units per gland **(max 1 injection per side)**
  - **Interval Between Treatments**: 16-24 weeks

Medication being provided by: Please check applicable box below.

- **Physician's office** **OR** - **Specialty Pharmacy**

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**: 5/22/2025
REVISED/UPDATED: 5/20/2025