AvMed

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 1-305-671-0200**. 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

Drug Requested: (check applicable drug below)

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

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

Member Name: _____

Member AvMed #: _____ **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:** _____

- **Maximum quantity limits:** 400 units in a 3-month period
- **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.

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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.

- ❑ Member must have **ONE** of the following diagnoses:
  - ❑ **Achalasia, Primary idiopathic esophageal AND meets ONE of the following:**
    - ❑ Member failed or had a clinically significant adverse reaction to conventional therapy (nitrates or calcium channel blockers)
    - ❑ Member is ineligible for surgical treatment due to advance age or multiple co-morbidities (poor surgical risk)
    - ❑ Member is at high risk of complications of pneumatic dilation or surgical myotome
    - ❑ Failure of prior myotomy or dilation
    - ❑ Member has an epiphrenic diverticulum or hiatal hernia, both of which increase the risk of dilation induced perforation
  - ❑ **Achalasia, Internal anal sphincter (IAS) AND meets BOTH of the following:**
    - ❑ Member has **NOT** responded to treatment with laxatives
    - ❑ Member has **NOT** responded to **OR** is **NOT** a candidate for anal sphincter myectomy
  - ❑ **Anal Fissure – Chronic AND meets the following criteria:**
    - ❑ 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**
  - ❑ **Motor tics**

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- ❑ **Neurogenic detrusor overactivity (NDO) and/or detrusor sphincter dyssynergia AND meets ALL the following:**
  - ❑ 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)**
  - ❑ Member meets **ONE** of the following age and prerequisite therapy requirements:
    - ❑ **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 AND** meets **ALL** the following
  - ❑ 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)
  - ❑ Trial and failure of **ONE** of the following medication regimens:
    - ❑ 2 anticholinergic agents and 1 β-3 adenoreceptor agonist (**requires PA**)
    - ❑ 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: 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.****