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: Daxxify® (daxibotulinumtoxinA-lanm)

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:** _____

- **Cosmetic indications are EXCLUDED**

Recommended Dosing: IM: Inject 125 to 250 units as a divided dose among affected muscles. Dose and number of injection sites should be individualized based on prior treatment, response, duration of effect, and adverse events. Dosage may be adjusted in 50- to 75-unit increments based on individual response; total recommended dose in a single treatment session: 125 to 250 units. Do not administer more frequently than every 3 months.

Maximum Quantity Limits: 250 units in a 3-month period

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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.

- ❑ Medication has been prescribed for the treatment of Cervical dystonia (spasmodic torticollis)
- ❑ Requested dosing is in accordance with the United States Food and Drug Administration (i.e., up to 250 cumulative units in a 3-month period)
- ❑ Member is **NOT** currently receiving therapy with another neuromuscular blocker agent, toxin (e.g., Botox®, Dysport®, Myobloc®, Xeomin®)

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/REFORMATTED: 5/20/2025