BOTULINUM TOXIN
Preauthorization Request
(Preauthorization is not a guarantee of payment)

SECTION I – General Information	
Today's Date: / /	☐ New request
Fax completed form to:**1-866-805-4150 toll free**	☐ Re-Authorization

Level of Urgency:

Standard Request (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature.

Expedited Request—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

For Expedited Request, Please Explain:

SECTION II – Member Information		
Patients Name:	Member ID:	**Patient Information**: DOB:__/__/__ Sex: Age: Weight: ☐ lbs. ☐ Kg Will the patient self-administer the requested medication? ☐ Yes ☐ No
Patients Address:	Is CBC primary payer: ☐ Yes ☐ No	

Plan Type:

☐ PPO ☐ POS ☐ KHPC ☐ CHIP (aka Capital Cares 4Kids)

☐ Traditional ☐ Comprehensive ☐ Special Care ☐ Other* _____

NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at https://www.covermymeds.com/main or via phone at 1-866-260-0452.

SECTION III – Provider Information Required	
Requesting Provider Name: **Address**:	**Requesting Provider CBC #**_____ **NPI #** _____
Telephone #:	Secure Fax #:
Office Contact Name:	Office Contact Telephone #:
Is the Rendering/Servicing provider different? ☐ No ☐ Yes – Complete rendering provider information below.	
Rendering Provider Name: **Address**: **Telephone:**	**Rendering Provider CBC #**_____ **NPI #** _____
Site of Service: ☐ MD Office ☐ Home Health ☐ Non-hospital affiliated, outpatient infusion center ☐ Hospital affiliated, outpatient infusion center ☐ Other: Specify _____ **Please refer to MP 3.016 for Site of Service requirements.*	**Check all that apply and include all applicable documentation:** ☐ There are contraindications to a less intensive site of care. ☐ A less intensive site of care is not appropriate for the patient's condition. ☐ Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently. ☐ Less intensive site of care is not available. **Please include all applicable documentation.*

SECTION IV – Preauthorization Requirements and Clinical Criteria	
Is the prescriber a specialist in the area of the patient's diagnosis or has the prescriber consulted with a specialist in the area of the patient's diagnosis? ☐ Yes Specialty: _____ ☐ No	
☐ New to therapy ☐ Continuing therapy*: Initial start __/__/__ ☐ Reinitiating therapy: Last treatment __/__/__ *Please include documentation for changes in dose.	**Route of Administration:** ☐ Intravenous (IV) ☐ Injection (Sub Q or IM) ☐ Oral (PO) or Enteral ☐ Other: Specify _____
HCPC Code(s):	**Diagnosis Code(s)**:
Medication requested:	**Indication:**
Type of drug requested: ☐ Brand name ☐ Generic ☐ Biosimilar ☐Other: Specify _____	
Initial start date of therapy: __/__/__	Anticipated date of **next administration:** __/__/__

Dosing period for request: Start Date: __/__/__ End Date __/__/__	**Dosing Information:** Dose: Strength: Frequency: Quantity requested per month:

Attach documentation demonstrating the medical necessity of the requested drug. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max.)

Has the patient had **medical testing** completed for use of this drug? (labs, imaging) ☐ Yes ☐ No

Results:_____

Is drug being requested for an "**off label**" indication or is dose outside of FDA recommendations? ☐ Yes ☐ No

If yes, please see Medical Policy 2.103 and include any applicable documentation.

Please list any previous medications that were **tried and failed**. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response, etc.). Please attach documentation.

Drug(s) and strength:

Documentation of failure:

***Include all applicable documentation for request.**

Complete all of the following:

Was the patient evaluated for any disorders which may contribute to respiratory or swallowing difficulty? □ Yes □ No

Does the patient have a hypersensitivity to any botulinum toxin product? □ Yes □ No

Does the patient have an active infection at the proposed injection site? □ Yes □ No

Is the patient on concurrent treatment with another botulinum toxin (i.e., abobotulinumtoxinA, incobotulinumtoxinA, rimabotulinumtoxinB, etc.)? □ Yes □ No

Complete the appropriate diagnosis section below:

Blepharospasms

Is the patient at least 12 years of age (unless otherwise specified)? □ Yes □ No

Cervical Dystonia Patient

Patient is at least 16 years of age? □ Yes □ No

Patient has a history of recurrent involuntary contraction of one or more muscles in the neck and upper shoulders? □ Yes □ No

Patient has sustained head tilt? □ Yes □ No

Patient has abnormal posturing with limited range of motion in the neck? □ Yes □ No

Strabismus

Patient is at least 12 years of age? □ Yes □ No

Spastic Conditions

Patient has the following: (check as appropriate – check mark indicated "yes" response)

- ☐ Upper/Lower Limb spasticity in adults (i.e., used post-stroke for spasms)
- ☐ Pediatric upper limb spasticity AND aged 2 years or greater (i.e., used post-stroke for spasms or for spasms related to cerebral palsy)
- ☐ Pediatric lower limb spasticity AND aged 2 years or greater
- ☐ Spasticity due to multiple sclerosis or Schilder's disease
- ☐ Acquired spasticity secondary to spinal cord or brain injuries
- ☐ Spastic Plegic conditions including Monoplegia, Diplegia, Hemiplegia, Paraplegia (including Hereditary spastic paraplegia), and Quadriplegia
- ☐ Hemifacial Spasm

Severe Primary Axillary Hyperhidrosis

Patient has tried and failed ≥ 1 month trial of a topical agent (i.e., 20% aluminum chloride, glycopyrronium, aluminum zirconium trichlorohydrate, etc.)? □ Yes □ No

Patient has a history of medical complications such as skin infections or significant functional impairments? □ Yes □ No

Patient has had a significant burden of disease or impact to activities of daily living due to condition (e.g., impairment in work performance/productivity, frequent change of clothing, difficulty in relationships and/or social gatherings, etc.)? □ Yes □ No

Prophylaxis for Chronic Migraines

Patient is utilizing prophylactic intervention modalities (i.e., avoiding migraine triggers, pharmacotherapy, behavioral therapy, physical therapy, etc.) ? □ Yes □ No

Patient has a diagnosis of chronic migraines defined by 15 or more headache (tension-type-like and/or migraine-like) days per month for at least 3 months? □ Yes □ No

Patient has had at least five attacks with features consistent with migraine (with and/or without aura)? □ Yes □ No

On at least 8 days per month for at least 3 months, headaches have characteristics and symptoms consistent with migraine§ ? □ Yes □ No

On at least 8 days per month for at least 3 months, patient suspected migraines are relieved by a triptan or ergot derivative medication? □ Yes □ No

Patient has failed at least an 8-week trial of any two oral medications for the prevention of migraines (see list of migraine-prophylactic medications below for examples) prior to initiation of onabotulinumtoxinA? □ Yes □ No

Esophageal Achalasia

Patient is at high risk of complication from pneumatic dilation, surgical myotomy, or peroral endoscopic myotomy (POEM)? □ Yes □ No

Patient has had treatment failure with pneumatic dilation, surgical myotomy, or POEM? □ Yes □ No

Patient has had perforation from pneumatic dilation? □ Yes □ No

Patient has an epiphrenic diverticulum or hiatal hernia? □ Yes □ No

Patient has esophageal varices? □ Yes □ No

Focal Dystonias

Focal upper limb dystonia with functional impairment? □ Yes □ No

Focal upper limb dystonia and pain as a result? □ Yes □ No

Laryngeal dystonia? □ Yes □ No

Oromandibular dystonia with functional impairment? □ Yes □ No

Oromandibular dystonia and pain as a result? □ Yes □ No

Sialorrhea associated with Neurological Disorders

Patient has a history of troublesome sialorrhea for at least a 3 month period? □ Yes □ No

Patient has Parkinson's disease? □ Yes □ No

Patient has severe developmental delays? □ Yes □ No

Patient has cerebral palsy? □ Yes □ No

Patient has amyotrophic lateral sclerosis? □ Yes □ No

Incontinence due to detrusor overactivity

Patient is at least 5 years of age? □ Yes □ No

Patient does not have a current, untreated urinary tract infection? □ Yes □ No

Patient has detrusor overactivity associated with a neurologic condition (i.e., spinal cord injury, multiple sclerosis, etc.) that is confirmed by urodynamic testing? □ Yes □ No

Patient has failed a 1 month or longer trial of two medications from either the antimuscarinic (i.e., darifenacin, fesoterodine, oxybutynin, solifenacin, tolterodine, or trospium) or beta-adrenergic (i.e., mirabegron) classes? □ Yes □ No

Overactive Bladder (OAB)

Patient does not have a current, untreated urinary tract infection? □ Yes □ No

Patient has symptoms of urge urinary incontinence, urgency, and frequency? □ Yes □ No

Patient has failed a 1 month or longer trial of two medications from either the antimuscarinic (i.e., darifenacin, fesoterodine, oxybutynin, solifenacin, tolterodine, or trospium) and/or beta-adrenergic (i.e., mirabegron) classes? □ Yes □ No

Severe Palmar Hyperhidrosis

Patient has tried and failed ≥ 1 month trial of a topical agent (i.e., 20% aluminum chloride, etc.)? □ Yes □ No

Patient has failed with iontophoresis? □ Yes □ No

Patient has a history of medical complications such as skin infections or significant functional impairments? □ Yes □ No

Patient has had a significant impact to activities of daily living due to condition? □ Yes □ No

Chronic Anal Fissure

Other causes of disease have been ruled out (i.e., Crohn's Disease, etc.)? □ Yes □ No

Patient has failed on non-pharmacologic supportive measures (i.e., sitz baths, psyllium fiber, bulking agents, etc.)? □ Yes □ No

Patient has tried and failed a ≥ 1 month trial of conventional pharmacologic therapy (i.e. oral/topical nifedipine, diltiazem, and/or topical nitroglycerin, bethanechol, etc.)? □ Yes □ No

Ventral Hernia

Patient has a large ventral hernia with loss of domain or contaminated ventral hernia? □ Yes □ No

Will be used preoperatively in patients scheduled to receive abdominal wall reconstruction (AWR)?

□ Yes □ No

Temporomandibular disorders (TMD)

Patient has a diagnosis of TMD with unilateral painful symptoms (i.e., pain upon opening the mouth and chewing, headache, joint clicking/ noise, etc.) lasting greater than 3 months? □ Yes □ No

Patient has tried and failed a 3 month trial of conventional noninvasive therapy (i.e., cognitive behavior therapy, pharmacotherapy, physical therapy, occlusal devices, etc.)? □ Yes □ No

Migraine-Prophylaxis Oral Medications (list not all-inclusive) •

Antidepressants (e.g., amitriptyline, fluoxetine, nortriptyline, etc.) • Beta blockers (e.g., propranolol, metoprolol, nadolol, timolol, atenolol, pindolol etc.) • Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (ex. lisinopril, candesartan, etc.) • Anti-epileptics (e.g., divalproex, valproate, topiramate, etc.) • Calcium channels blockers (e.g., verapamil, etc.)

Migraine Features

Migraine without aura •

At least five attacks have the following:

o Headache attacks lasting 4-72 hours (untreated or unsuccessfully treated)

o Headache has at least two of the following characteristics: Unilateral location, pulsating quality, moderate or severe pain intensity, aggravation by or causing avoidance of routine physical activity (e.g., walking or climbing stairs); AND

o During headache at least one of the following: Nausea and/or vomiting; Photophobia and phonophobia

Migraine with aura

• At least two attacks have the following:

o One or more of the following fully reversible aura symptoms: Visual, sensory, speech and/or language, motor, brainstem, retinal; AND

o At least three of the following characteristics: at least one aura symptom spreads gradually over ≥5 minutes, two or more symptoms occur in succession, each individual aura symptom lasts 5 to 60 minutes, at least one aura symptom is unilateral, at least one aura symptom is positive (e.g., scintillations and pins and needles), the aura is accompanied, or followed within 60 minutes, by headache

Renewal Criteria
(complete if drug is being renewed – in addition to above)

Has the patient experienced unacceptable toxicity* from the drug? □ Yes □ No

** Examples of unacceptable toxicity include: symptoms of a toxin spread effect and clinically significant effects with pre-existing neuromuscular disorders (i.e., asthenia, generalized muscle weakness, diplopia, ptosis, dysphagia, dysphonia, dysarthria, urinary incontinence, swallowing/breathing difficulties, etc.), severe hypersensitivity reactions (i.e., anaphylaxis, serum sickness, urticaria, soft tissue edema, and dyspnea), severe pulmonary effects (i.e., reduced pulmonary function), corneal exposure/ulceration, retrobulbar hemorrhage, bronchitis/upper-respiratory tract infections, autonomic dysreflexia, urinary tract infection, and urinary retention, etc.*

Has the patient experienced a disease response? (complete under appropriate diagnosis)

Blepharospasms

Has the patient experienced the following disease response: improvement of severity and/or frequency of eyelid spasms? □ Yes □ No

Cervical dystonia

Has the patient experienced the following disease response: improvement in the severity and frequency of pain AND improvement of abnormal head positioning? □ Yes □ No

Strabismus

Has the patient experienced the following disease response: Improvement in alignment of prism diopters compared to pre-treatment baseline □ Yes □ No

Focal Upper/Lower Limb Spasticity

Has the patient experienced the following disease response: Decrease in tone and/or resistance, of affected areas, based on a validated measuring tool (i.e., Ashworth Scale, Physician Global Assessment, Clinical Global Impression (CGI), etc.)? □ Yes □ No

Hemifacial Spasms

Has the patient experienced the following disease response: Decrease in frequency and/or severity of spasm, or a decrease in tone and/or improvement in asymmetry to the affected side of the face? □ Yes □ No

Severe Primary Axillary Hyperhidrosis

Has the patient experienced the following disease response: Significant reduction in spontaneous axillary sweat production AND patient has a significant improvement in activities of daily living? □ Yes □ No

Prophylaxis for Chronic Migraines

Has the patient experienced a disease response as outlined below:

Significant decrease in the number, frequency, and/or intensity of headaches? □ Yes □ No

Improvement in function? □ Yes □ No

Patient continues to utilize prophylactic intervention modalities (i.e., pharmacotherapy, behavioral therapy, physical therapy, etc.)? □ Yes □ No

Esophageal Achalasia

Has the patient experienced a disease response as outlined by either of the following? □ Yes □ No

Improvement and/or relief in symptoms (i.e., dysphagia, pain, etc.); OR

Improvement in esophageal emptying as evidenced by functional testing

Focal Dystonias

Has the patient experienced a disease response as outlined below:

Focal upper limb dystonia

o Improvement in pain and/or function? □ Yes □ No □ NA

Laryngeal dystonia

o Improvement in voice function or quality? □ Yes □ No □ NA

Oromandibular dystonia

o Improvement in pain and function? □ Yes □ No □ NA

Sialorrhea associated with Neurological Disorders

Has the patient experienced the following disease response:

Significant decrease in saliva production? □ Yes □ No

Incontinence due to Detrusor Overactivity

Has the patient experienced a disease response as outlined below?

- Patient does not have a current, untreated urinary tract infection? □ Yes □ No
- Significant improvements in weekly frequency of incontinence episodes? □ Yes □ No
- Patient's post-void residual (PVR) periodically assessed as medically appropriate? □ Yes □ No

Overactive Bladder (OAB)

Has the patient experienced a disease response as outlined below?

• Patient does not have a current, untreated urinary tract infection? □ Yes □ No

• Significant improvement in daily frequency of urinary incontinence or micturition episodes and/or volume voided per micturition? □ Yes □ No

• Patient's post-void residual (PVR) periodically assessed as medically appropriate? □ Yes □ No

Severe Palmar Hyperhidrosis

Has the patient experienced a disease response as outlined below?

• Significant reduction in spontaneous palmar sweat production? □ Yes □ No

• Patient has a significant improvement in activities of daily living? □ Yes □ No

Chronic Anal Fissure

Has the patient experienced either of the following disease response?

• Complete healing of anal fissure? □ Yes □ No

• Symptomatic improvement of persistent fissures? □ Yes □ No

Spastic Conditions, Other (Plegias, etc.)

Has the patient experienced the following disease response? □ Yes □ No

Decrease in tone and/or resistance, of affected areas, based on a validated measuring tool (i.e., Ashworth Scale, Physician Global Assessment, Clinical Global Impression (CGI), etc.) □ Yes □ No

Ventral Hernia

May not be renewed

Temporomandibular Disorders (TMD)

Has the patient experienced the following disease response?

• Patient has significant improvement in symptoms (i.e., pain upon opening the mouth and chewing, headache, joint clicking/ noise, etc.) ? □ Yes □ No

Please use a separate form for each drug. To fill out form type or write using blue or black ink **Please fax this form to: 1-866-805-4150** Telephone: 1-800-471-2242	**CONFIDENTIALITY NOTICE**: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 1-800-471-2242. Thank you for your cooperation.
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