Capital

BOTOX® (ONABOTULINUMTOXINA)
PREAUTHORIZATION REQUEST
(PREAUTHORIZATION IS NOT A GUARANTEE OF PAYMENT)

SECTION I – General information	
Today's date: / /	☐ New request
Fax completed form to: **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.
- 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 Capital Blue Cross primary payer: ☐ Yes ☐ No	

Plan Type:

☐ PPO ☐ POS ☐ KHPC ☐ CHIP
☐ Traditional ☐ Comprehensive ☐ Special Care ☐ Other* _____

NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at www.covermymeds.com/main or via phone at 866.260.0452.

SECTION III – Provider information required	
Requesting provider name: **Address**:	**Requesting provider Capital #**_____ **NPI #** _____
Telephone #:	Secure fax #:

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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 Capital #**_____ **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. _____
HCPCS 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:
<u>Attach documentation demonstrating the medical necessity of the requested drug.</u> 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: _____	

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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:

Complete all of the following universal criteria questions

Is the patient at least 18 years of age (unless otherwise specified)? ☐ Yes ☐ No

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**

Patient is 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 one of the following:

- ☐ Upper/lower limb spasticity in adults (i.e., used post-stroke for spasms)
- ☐ Pediatric upper limb spasticity in patient at least 2 years of age (i.e., used post-stroke for spasms or for spasms related to cerebral palsy)
- ☐ Pediatric lower limb spasticity in patient at least 2 years of age
- ☐ 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 > 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 > 3 months:

- Headaches have characteristics and symptoms consistent with migraines. □ Yes □ No
- 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 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**

Patient has focal upper limb dystonia with functional impairment. □ Yes □ No

Patient has focal upper limb dystonia and pain as a result. □ Yes □ No

Patient has laryngeal dystonia. □ Yes □ No

Patient has oromandibular dystonia with functional impairment. □ Yes □ No

Patient has 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

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☐**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, vibegron) 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

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.*

Complete the appropriate diagnosis section below for renewal:

☐**Blepharospasms**

The patient has improvement of severity and/or frequency of eyelid spasms. □ Yes □ No

☐**Cervical dystonia**

The patient has improvement in the severity and frequency of pain AND improvement of abnormal head positioning.

□ Yes □ No

☐**Strabismus**

The patient has improvement in alignment of prism diopters compared to pre-treatment baseline. □ Yes □ No

☐**Focal Upper/Lower Limb Spasticity**

The patient has 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**

The patient has 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

The patient has a significant reduction in spontaneous axillary sweat production AND patient has a significant improvement in activities of daily living. □ Yes □ No

□Prophylaxis for Chronic Migraines

The patient has a significant decrease in the number, frequency, and/or intensity of headaches. □ Yes □ No

The patient has a significant improvement in function. □ Yes □ No

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

□Esophageal Achalasia

The patient has improvement and/or relief in symptoms (i.e., dysphagia, pain, etc.), or improvement in esophageal emptying as evidenced by functional testing. □ Yes □ No

□Focal Dystonia

Has the patient experienced a disease response as outlined below:

- □ Focal upper limb dystonia
  - Improvement in pain and/or function □ Yes □ No
- □ Laryngeal dystonia
  - o Improvement in voice function or quality □ Yes □ No
- □ Oromandibular dystonia
  - o Improvement in pain and function □ Yes □ No

□Sialorrhea associated with Neurological Disorders

Patient has significant decrease in saliva production. □ Yes □ No

□Incontinence due to Detrusor Overactivity

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

Patient has 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)

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

Patient has 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

Patient has experienced a significant reduction in spontaneous palmar sweat production and a significant improvement in activities of daily living. □ Yes □ No

□Chronic Anal Fissure

Patient has experienced complete healing of anal fissure or symptomatic improvement of persistent fissures.

□ Yes □ No

□Spastic Conditions, Other

Patient has 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

□Temporomandibular Disorders (TMD)

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: 866.805.4150.** Telephone: 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 800.471.2242. Thank you for your cooperation.
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