Updated: 12/2018
PARP Approved: 12/2018

Prior Authorization Criteria

Qbrexza (glycopyrronium)

All requests for Qbrexza (glycopyrronium) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of primary axillary hyperhidrosis and the following criteria is met:

- The member must be 9 years of age or older
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- There is documentation that the axillary hyperhidrosis is severe, intractable and disabling in nature as documented by at least one of the following:
    - Significant disruption of professional and/or social life as a result of excessive sweating
    - The condition is causing persistent or chronic cutaneous conditions (e.g., skin maceration, dermatitis, fungal infections, secondary microbial infections)
- Potential causes of secondary hyperhidrosis have been ruled out (e.g., hyperthyroidism)
- Documentation of a baseline sweating scale score (examples include the Hyperhidrosis Disease Severity Scale (HDSS) or the Axillary Sweating Daily Diary (ASDD))
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to the following:
    - For members under 18
        - At least 2 months of topical aluminum chloride 20%
    - For members 18 years of age and older
        - At least 2 months of topical aluminum chloride 20%
        - At least 6 months of Botox (this requires a prior authorization)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Documentation of a sweating scale assessment score that has improved from baseline
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

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QBREXZA (GLYCOPYRRONIUM) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis ☐ Primary axillary hyperhidrosis ☐ Other _____

Is there documentation the axillary hyperhidrosis is severe, intractable and disabling? ☐ Yes ☐ No

Is there significant disruption of professional and/or social life as a result of excessive sweating? ☐ Yes ☐ No

Does the condition cause persistent or chronic cutaneous conditions (e.g. skin macerations, dermatitis, fungal infections, secondary microbial infections)? ☐ Yes ☐ No

Has secondary hyperhidrosis been ruled out? ☐ Yes ☐ No

Baseline sweating scale score: _____ Name of scale used: _____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No

Please provide sweating scale score since starting therapy: _____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date