



Updated: 04/2023  
DMMA Approved: 04/2023

Request for Prior Authorization for Botulinum Toxins  
Website Form – [www.highmarkhealthoptions.com](http://www.highmarkhealthoptions.com)  
Submit request via: Fax - 1-855-476-4158

All requests for Botulinum Toxins require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Botulinum Toxins include Botox (onabotulinumtoxinA), Dysport (abobotulinumtoxinA), Myobloc (rimabotulinumtoxinB), and Xeomin (incobotulinumtoxinA). New products with this classification will require the same documentation.

### **Botulinum Toxins Prior Authorization Criteria:**

For all requests the following criteria must be met in addition to the diagnosis specific criteria below:

- Must have a therapeutic failure, contraindication, or intolerance to Dysport and Xeomin when FDA-approved or medically accepted for the member's diagnosis.
- Must be prescribed for an FDA-approved or medically accepted indication
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines

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

- There is documentation that the axillary hyperhidrosis is severe, intractable and disabling in nature as documented by:
  - 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)
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to at least 2 months of topical aluminum chloride 20%

Coverage may be provided with a diagnosis of **strabismus** or **blepharospasm associated with dystonia**, including benign essential blepharospasm or VII nerve disorder

Coverage may be provided with a diagnosis of **cervical dystonia (spasmodic torticollis)**

Coverage may be provided with the diagnosis of **spasticity** and the following criteria is met:

- Must meet one of the following:
  - Spasticity interferes with activities of daily living
  - Spasticity is expected to result in joint contracture with future growth

Coverage may be provided with a diagnosis of **chronic migraine** as prophylaxis and the following criteria is met:

- The member has at least 15 headache days per month for at least 3 months with headache lasting at least four hours per day
- Must provide documentation showing the member has tried and failed for at least 2 months (at optimal or maximum tolerated dose) or had an intolerance or contraindication to at least three migraine prophylaxis agents (e.g., topiramate, propranolol, metoprolol, divalproex, sodium valproate)
- The member has had a trial and failure of a preferred injectable antimigraine prophylaxis agent or submitted a clinical reason for not having a trial of a preferred agent

Coverage may be provided with a diagnosis of **urinary incontinence due to detrusor overactivity** associated with neurologic conditions (e.g. spinal cord injury, MS) OR **overactive bladder (OAB)** with symptoms of urge urinary incontinence, urgency, and frequency and the following criteria is met:

- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to two anticholinergic medication (e.g., solifenacin, oxybutynin)

**Initial Duration of Approval:** 12 months

**Reauthorization criteria:**

- Documentation of clinical benefit and tolerance to therapy.

**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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

**BOTULINUM TOXINS  
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE: (844) 325-6251 Mon – Fri 8 am to 7 pm**

**PROVIDER INFORMATION**

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

**MEMBER INFORMATION**

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

**REQUESTED DRUG INFORMATION**

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No      Date Medication Initiated:		
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Billing Information**

This medication will be billed: <input type="checkbox"/> at a pharmacy <b>OR</b> <input type="checkbox"/> medically, JCODE:		
Place of Service: <input type="checkbox"/> Hospital <input type="checkbox"/> Provider's office <input type="checkbox"/> Member's home <input type="checkbox"/> Other		

**Place of Service Information**

Name:	NPI:
Address:	Phone:

**MEDICAL HISTORY (Complete for ALL requests)**

Diagnosis:	ICD Code:
------------	-----------

**For chronic migraine prophylaxis:**

- Does the member have headaches occurring on 15 or more days a month for at least 3 months?  Yes  No
- Do the headaches last at least 4 hours per day?  Yes  No
- Has the member tried 3 migraine prophylaxis agents?  Yes, please list below     No

**For axillary hyperhidrosis:**

- Is the hyperhidrosis severe, intractable and disabling?  Yes  No
- Has topical aluminum chloride 20% been tried for at least two months?  Yes  No

**For urinary incontinence associated with neurologic conditions OR overactive bladder:**

- Has the member tried 2 anticholinergic medications?  Yes, please list below     No

**For spasticity:**

- Does it interfere with daily living **OR** expected to result in joint contracture with future growth?  Yes  No

**CURRENT or PREVIOUS THERAPY**

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

**REAUTHORIZATION**

Is there documentation of clinical benefit and tolerance to therapy?  Yes     No

**SUPPORTING INFORMATION or CLINICAL RATIONALE**

Prescribing Provider Signature	Date
--------------------------------	------