Updated: 09/2018
PARP Approved: 10/2018

Prior Authorization Criteria

Botox (onabotulinumtoxinA)

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

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

- The member is 18 years of age and older
- 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)
    - Condition is refractory to at least two months of continuous treatment with topical agents (unless agents results in severe dermatitis)

Coverage may be provided with the diagnosis of strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorder and the following criteria is met:

- The member is 12 years of age and older
- The member has vision in both eyes and is unable to maintain fusion of an image and has at least one of the following;
    - Diplopia
    - Abnormal head turn
    - Asthenopia
    - Impairment of peripheral vision due to esotropia

Coverage may be provided with the diagnosis of cervical dystonia (spasmodic torticollis) and the following criteria is met:

- The member is 16 years of age and older
- The member demonstrates an abnormal head position (sustained head tilt or abnormal posturing with limited range of motion in the neck) and if applicable, neck pain associated with cervical dystonia
- Alternative causes of the member's symptoms have been considered and ruled out, including chronic neuroleptic treatment, contractures, or other neuromuscular disorders
- No prior surgical treatment

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

- The member is 18 years of age and older
- The member has been diagnosed with chronic headache:

    - Defined by at least 15 headaches days per month, lasting at least four hours per day
- There is documentation that the member has experienced an inadequate response to, is intolerant of, or has a contraindication to at least two of the following migraine prophylaxis agents
    - Topiramate, propranolol, metoprolol, divalproex, timolol, amitriptyline, sodium valproate

Coverage may be provided with the diagnosis of incontinence due to detrusor instability associated with neurologic conditions (spinal cord injury, MS) and the following criteria is met:
- The member is 18 years of age and older
- There is documentation that the member has experienced an inadequate response to, is intolerant of, or has a contraindication to at least one anticholinergic medication (e.g., Toviaz, oxybutynin)
- Failure of behavioral therapy (pelvic floor exercises, cognitive behavioral therapy, fluid management, bladder exercises or weight loss)

Coverage may be provided with the diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency and the following criteria is met:
- The member is 18 years of age and older
- There is documentation that the member has experienced an inadequate response to, is intolerant of, or has a contraindication to at least one anticholinergic medication (e.g., Toviaz, oxybutynin)
- Failure of behavioral therapy (pelvic floor exercises, cognitive behavioral therapy, fluid management, bladder exercises or weight loss)

Coverage may be provided with the diagnosis of upper limb spasticity, including elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris), and finger flexors (flexor digitorum profundus and flexor digitorum sublimis) and lower limb spasticity including ankle and toe muscles (gastrocnemius, soleus, tibialis posterior, flexor halluces longus, and flexor digitorum longus) and the following criteria is met:
- The member is 18 years of age and older
- There is documentation that abnormal muscle tone is interfering with functional ability or it is expected to result in joint contracture with future growth
- Documentation of failure of standard medical treatments (e.g., physical/occupational therapy, electrical stimulation, biofeedback, and orthotics)

Exclusion criteria:
- Hypersensitivity to any botulinum toxin preparation or to any of the components in the formulation
- Infection at the injection site
- Urinary Tract Infection or Urinary Retention

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.

Gateway Health

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BOTOX (Botulinum Toxin)
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[SM] 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 Physician:	NPI:
Physician Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	
Health Options ID:	DOB:

DRUG INFORMATION

Medication:	**Strength:**
Frequency:	**Duration:**

BILLING INFORMATION

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

Place of service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Infusion Center ☐ Other

PLACE OF SERVICE INFORMATION

Name:	**NPI:**
Address:	**Phone:**

MEDICAL HISTORY

Diagnosis: _____ **Diagnosis code:** _____

For chronic migraine prophylaxis:
Has the member been diagnosed with chronic headache? ☐ Yes ☐ No
How many headache days per month? _____ What is the duration of headaches? _____
Is there documentation the member has experienced an inadequate response to, is tolerant of, or has a contraindication to at least 2 migraine prophylaxis agents? ☐ Yes, please provide details below ☐ No: _____

For axillary hyperhidrosis?
Is there documentation the axillary hyperhidrosis is severe, intractable and disabling? ☐ Yes ☐ No
Is the condition refractory to at least two months of continuous treatment with topical agents? ☐ Yes ☐ No
If **no**, please provide clinical rationale below.

For strabismus and blepharospasm associated with dystonia:
Does the member have vision in both eyes? ☐ Yes ☐ No
Is the member unable to maintain fusion of an image and has at least **one** of the following: diplopia, abnormal head turn, astehnopia or impairment of peripheral vision due to esotropia? ☐ Yes ☐ No

For incontinence due to detrusor instability associated with neurologic conditions OR overactive bladder:
Is there documentation the member has experienced an inadequate response to, is intolerant of, or has a contraindication to at least **one** anticholinergic medication? ☐ Yes, please provide details below ☐ No
Has the member tried and failed behavioral therapy? ☐ Yes ☐ No

For upper and lower limb spasticity:
Is there documentation that abnormal muscle tone is interfering with functional ability OR is expected to result in joint contracture with future growth? ☐ Yes ☐ No
Is there documentation of failure of standard medical treatments? ☐ Yes, please provide details below ☐ No

For cervical dystonia (spasmodic torticollis):

Does the member demonstrate an abnormal head position and neck pain associated with cervical dystonia?
☐ Yes ☐ No
Have alternative causes been considered and ruled out, including chronic neuroleptic treatment, contractures or other neuromuscular disorders? ☐ Yes ☐ No
Has the member had prior surgical treatment? ☐ Yes ☐ No

REAUTHORIZATION

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

PREVIOUS PHARMACOLOGIC THERAPY

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

ADDITIONAL SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Physician Signature	Date