

Prior Authorization Criteria
Obrexza (glycopyrronium)

All requests for Obrexza (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)
- 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%
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
 - Documentation of improvement 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.

**QUREXZA (GLYCOPYRROLIUM)
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 Wholecare Pharmacy Services. **FAX:** (888) 245-2049

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE:** (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Member ID:	Member weight: Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:
Directions:	Quantity: Refills:
<input type="checkbox"/>	Date Medication Initiated:

Billing Information

This medication will be billed: at a pharmacy OR medically, 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:	ICD Code:
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

CURRENT or PREVIOUS THERAPY

Yes No
<input type="checkbox"/> Yes

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Has the member experienced improvement with treatment?	Yes No
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SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date