Updated: 08/2020
DMMA Approved: 08/2020

Request for Prior Authorization for Botox
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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

Botox Prior Authorization Criteria:

For all requests for Botox (onabotulinumtoxinA) all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

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

- The member is 18 years of age and older
- 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 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 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) and the following criteria is met:

- The member is 18 years of age and older
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to two anticholinergic medication (e.g., Vesicare, oxybutynin)
- Failure of behavioral therapy (pelvic floor exercises, cognitive behavioral therapy, fluid management, bladder exercises or weight loss)

Coverage may be provided with a diagnosis of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and frequency and the following criteria is met:

- The member is 18 years of age and older
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to two anticholinergic medications (e.g., Vesicare, 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 spasticity and the following criteria is met:

- The member is 2 years of age or 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)

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.

HIGHMARK. Delaware HEALTH OPTIONS

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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 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 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:
Health Options 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:

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? ☐ Yes ☐ No

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: _____ **Diagnosis 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 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, asthenopia or impairment of peripheral vision due to esotropia? ☐ Yes ☐ No

For urinary incontinence associated with neurologic conditions OR overactive bladder:
- Has the member tried 2 anticholinergic medications? ☐ Yes, please list below ☐ No
- Has the member tried and failed behavioral therapy (e.g. exercise, weight loss, fluid management)? ☐ Yes ☐ No

For spasticity:
- Does it interfere with functional ability OR expected to result in joint contracture with future growth? ☐ Yes ☐ No
- Have standard medical treatments been tried? ☐ Yes, please provide details below ☐ No

For cervical dystonia (spasmodic torticollis):
- Does the member demonstrate an abnormal head position? ☐ Yes ☐ No
- Have alternative causes been ruled out? ☐ Yes ☐ No
- Has the member had prior surgical treatment? ☐ Yes ☐ No

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BOTOX (BOTULINUM TOXIN)
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

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MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

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