Updated: 04/2024
DMMA Approved: 04/2024

**Request for Prior Authorization for Qbrexza (glycopyrronium)**
**Website Form – www.highmarkhealthoptions.com**
**Submit request via: Fax - 1-855-476-4158**

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

**Qbrexza (glycopyrronium) Prior Authorization Criteria:**

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

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 HEALTH OPTIONS

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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 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: | |
| Member ID: | Member weight: | Height: |

## REQUESTED DRUG INFORMATION

| | | |
|---|---|---|
| Medication: | Strength: | |
| Directions: | Quantity: | Refills: |
| 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: | 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

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

## REAUTHORIZATION

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

## SUPPORTING INFORMATION or CLINICAL RATIONALE

| |
|---|
| |
| |
| |

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