Updated: 07/2019
DMMA Approved: 07/2019

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
- 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)
- Documentation of a baseline sweating scale score (examples include the Hyperhidrosis Disease Severity Scale (HDSS) or the Axillary Sweating Daily Diary (ASDD))
- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to the following:
    - For members under 18
        - At least 2 months of topical aluminum chloride 20%
    - For members 18 years of age and older
        - At least 2 months of topical aluminum chloride 20%
        - At least 6 months of Botox (this requires a prior authorization)
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Documentation of a sweating scale assessment score that has improved 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.

Highmark Delaware 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) 325-6253 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 (if medically please provide a 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 ☐ Primary axillary hyperhidrosis ☐ Other _____

- 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
- Baseline sweating scale score: _____ Name of scale used: _____

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please provide sweating scale score since starting therapy: _____

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date