Capital

# BOTULINUM TOXIN
## Preauthorization Request
## (Preauthorization is not a guarantee of payment)

**SECTION I – General Information**

| | |
|---|---|
| Today's Date: / / | ☐ New request |
| Fax completed form to:**1-866-805-4150 toll free** | ☐ Re-Authorization |

**Level of Urgency:**

**Standard Request** (Routine Care)—Care/treatment that is not emergent, urgent, or preventive in nature.

**Expedited Request**—Care/treatment that is emergent or the application of the timeframe for making Standard/Routine or nonlife-threatening care determinations:

- Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
- In the opinion of the practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

**For Expedited Request, Please Explain:**

**SECTION II – Member Information**

| | | |
|---|---|---|
| Patients Name: | Member ID: | **Patient Information**:<br>DOB:__/__/__<br>Sex:<br>Age:<br>Weight: ☐ lbs. ☐ Kg<br>Will the patient self-administer the requested medication?<br>☐ Yes ☐ No |
| Patients Address: | Is CBC primary payer:<br>☐ Yes<br>☐ No | |

Plan Type:

☐ PPO ☐ POS ☐ KHPC ☐ CHIP (aka Capital Cares 4Kids)

☐ Traditional ☐ Comprehensive ☐ Special Care ☐ Other* _____

***NOTE: For all Medicare Advantage products, please contact Prime Therapeutics at https://www.covermymeds.com/main or via phone at 1-866-260-0452.***

**SECTION III – Provider Information Required**

| | |
|---|---|
| **Requesting Provider Name**:<br>**Address**: | **Requesting Provider CBC #**_____<br>**NPI #** _____ |
| Telephone #: | Secure Fax #: |
| Office Contact Name: | Office Contact Telephone #: |

**Is the Rendering/Servicing provider different?** ☐ No ☐ Yes – Complete rendering provider information below.

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| | |
|---|---|
| **Rendering Provider Name**:<br>**Address**:<br>**Telephone:** | **Rendering Provider CBC #**_____<br>**NPI #** _____ |

| | |
|---|---|
| **Site of Service:**<br>☐ MD Office<br>☐ Home Health<br>☐ Non-hospital affiliated, outpatient infusion center<br>☐ Hospital affiliated, outpatient infusion center<br>☐ Other: Specify _____<br><br>**Please refer to MP 3.016 for Site of Service requirements.* | **Check all that apply and include all applicable documentation:**<br>☐ There are contraindications to a less intensive site of care.<br>☐ A less intensive site of care is not appropriate for the patient's condition.<br>☐ Patient is being treated with a drug that cannot be administered in a less intensive site of care concurrently.<br>☐ Less intensive site of care is not available.<br><br>**Please include all applicable documentation.* |

**SECTION IV – Preauthorization Requirements and Clinical Criteria**

Prescribed in consultation with a specialist? ☐ Yes Specialty: _____ ☐ No

| | |
|---|---|
| ☐ New to therapy<br>☐ Continuing therapy*: Initial start __/__/__<br>☐ Reinitiating therapy: Last treatment __/__/__<br>*Please include documentation for changes in dose. | **Route of Administration:**<br>☐ Intravenous (IV)<br>☐ Injection (Sub Q or IM)<br>☐ Oral (PO) or Enteral<br>☐ Other: Specify _____ |
| **HCPC Code(s):** | **Diagnosis Code(s)**: |
| **Medication requested:** | **Indication:** |

Type of drug requested: ☐ Brand name ☐ Generic ☐ Biosimilar ☐ Other: Specify _____

| | |
|---|---|
| **Initial start** date of therapy: __/__/__ | Anticipated date of **next administration:** __/__/__ |

| | |
|---|---|
| **Dosing period for request:**<br><br>Start Date: __/__/__<br>End Date __/__/__ | **Dosing Information:**<br>Dose:<br>Strength:<br>Frequency:<br>Quantity requested per month: |

**Attach documentation demonstrating the medical necessity of the requested drug.** Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max.)

Has the patient had **medical testing** completed for use of this drug? (labs, imagining) ☐ Yes ☐ No

Results:_____

Is drug being requested for an "**off label**" indication or is dose outside of FDA recommendations? ☐ Yes ☐ No

If yes, please see Medical Policy 2.103 and include any applicable documentation.

Please list any previous medications that were **tried and failed**. Include reason for discontinuation (intolerance, hypersensitivity, inadequate response etc.). Please attach documentation.

Drug(s) and strength:

Documentation of failure:

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**Initial Evaluation for Botulinum Toxin agents**

- Will the patient be using the requested agent for cosmetic purposes (e.g., glabellar lines, wrinkles)? ☐ Yes ☐ No
- If the patient has any of the conditions listed below, check the appropriate box and answer the appropriate questions.

☐ Blepharospasm (including benign essential blepharospasm or VII nerve disorders)

- Is the blepharospasm associated with dystonia? ☐ Yes ☐ No

☐ Cervical dystonia (spasmodic torticollis; applicable whether congenital, due to child birth injury, or traumatic injury)

- Is the patient's cervical dystonia associated with sustained head tilt or abnormal posturing with limited range of motion in the neck? ☐ Yes ☐ No
- Does the patient have a history of recurrent involuntary contraction(s) of one or more of the muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, or posterior cervical muscles)? ☐ Yes ☐ No

☐ Hemifacial spasm

☐ Primary axillary hyperhidrosis

- Has the patient had focal, visible, excessive sweating of at least 6 months duration without apparent cause with at least TWO of the following characteristics: ☐ Yes ☐ No
  - ☐ Bilateral and relatively symmetric
  - ☐ Impairs daily activities
  - ☐ Frequency of at least one episode per week
  - ☐ Age of onset is less than 25 years
  - ☐ Positive family history
  - ☐ Cessation of focal sweating during sleep
- Has the patient tried and had an inadequate response to 20% aluminum based topical antiperspirant (e.g., Drysol, OTC)? ☐ Yes ☐ No
- Does the patient have a documented intolerance, FDA labeled contraindication, or hypersensitivity to 20% aluminum based topical antiperspirant (e.g., Drysol, OTC)? ☐ Yes ☐ No

☐ Chronic migraine

- Does the patient have chronic migraine as defined by having **BOTH** ≥15 headache days per month of migraine-like or tension-like headache for a minimum of 3 months, **AND** ≥8 migraine headache days per month for a minimum of 3 months? ☐ Yes ☐ No
- Has the patient tried and had an inadequate response to at least TWO migraine prophylaxis classes (anticonvulsants [i.e., divalproex, valproate, topiramate], beta blockers [i.e., atenolol, metoprolol, nadolol, propranolol, timolol], antidepressants [i.e., amitriptyline, venlafaxine], CGRP [e.g., Aimovig, Ajovy, Emgality]) after an adequate trial as defined by **BOTH** a trial length of at least 6 weeks for each class at generally accepted doses **AND** the patient was ≥80% adherent to the prophylaxis agent during the trial? ☐ Yes ☐ No
- Does the patient have an intolerance or hypersensitivity to at least TWO migraine prophylaxis classes (anticonvulsants, beta blockers, antidepressants, AND prophylactic CGRPs listed above? ☐ Yes ☐ No
- Does the patient have an FDA labeled contraindication to ALL anticonvulsants, beta blockers, antidepressants, AND prophylactic CGRPs listed above? ☐ Yes ☐ No
- Is the prescriber a headache specialist (e.g., neurologist; pain management specialist; or specialist with United Council for Neurologic Subspecialties [UCNS] certification) or has consulted with a headache specialist? ☐ Yes ☐ No
- Has the patient been evaluated for medication overuse headaches? ☐ Yes ☐ No

☐ Neurogenic bladder with detrusor muscle overactivity

- Has the patient tried and had an inadequate response to ONE anticholoinergic agent (e.g., oxybutynin, tolterodine, trospium, darifenacin, solifenacin or fesoterodine) **AND** Myrbetrig/mirabegron ☐ Yes ☐ No
- Does the patient have an intolerance or hypersensitivity to ONE anticholinergic agent **AND** Myrbetrig/mirabegron ☐ Yes ☐ No

- Does the patient have an FDA labeled contraindication to ALL anticholinergic agents **AND** myrbetrig/mirabegron. ☐ Yes ☐ No

☐ Strabismus (includes persistent cranial VI nerve palsy of one month or longer)

- Has the patient had an inadequate response to corrective lenses? ☐ Yes ☐ No
- Has the patient had an inadequate response to any other additional, patient appropriate, conservative corrective therapies (e.g., exercises)? ☐ Yes ☐ No
- Does the patient have good vision in both eyes? ☐ Yes ☐ No
- Are the patient's eye movements restricted? ☐ Yes ☐ No
- Does the patient have small to moderate angle of esotropia? ☐ Yes ☐ No
- Is there a potential for the patient to experience binocular vision? ☐ Yes ☐ No

☐ Spasticity

- Is the spasticity in the upper limbs? ☐ Yes ☐ No
- Has the patient tried physical/occupational therapy, bracing/splinting, with inadequate results? ☐ Yes ☐ No
- Has the patient tried and had an inadequate response to **OR** has an intolerance or hypersensitivity to to ONE conventional prerequisite agent (e.g., benzodiazepine, oral or intrathecal baclofen)? ☐ Yes ☐ No
- Does the patient have an FDA labeled contraindication to ALL conventional prerequisite agents? ☐ Yes ☐ No

☐ Overactive bladder

- Does the patient have symptoms of urge urinary incontinence, urgency, and frequency? ☐ Yes ☐ No
- Has the patient tried and had an inadequate response to conservative therapies including bladder training, pelvic floor muscle exercises, and fluid management for at least 2-months? ☐ Yes ☐ No
- Has the patient tried and had an inadequate response to ONE anticholinergic agent (e.g., oxybutynin, tolterodine, trospium, darifenacin, solifenacin or fesoterodine) for at least 1-month **AND** Myrbetriq/mirabegron for at least one month? ☐ Yes ☐ No
- Does the patient have an intolerance or hypersensitivity to ONE anticholinergic agent **AND** Myrbetriq/mirabegron? ☐ Yes ☐ No
- Does the patient have an FDA labeled contraindication to ALL anticholinergic agents **AND** Myrbetriq/mirabegron? ☐ Yes ☐ No

☐ Sialorrhea associated with Parkinson's Disease **OR** ☐ Chronic Sialorrhea

- Has the patient tried and had an inadequate response to ONE conventional prerequisite agent (e.g., benztropine, oral hyoscyamine, glycopyrrolate)? ☐ Yes ☐ No
- Does the patient have an intolerance or hypersensitivoty to ONE conventional prerequisite agent **OR** an FDA labeled contraindication to ALL conventional prerequisite agents? ☐ Yes ☐ No

☐ Does the patient have another FDA approved indication that is not listed above? ☐ Yes ☐ No

If yes, please specify. _____

- Is the patients age within FDA labeling for the requested indication **OR** is information provided in support of using the requested agent for the patient's age? ☐ Yes ☐ No
- Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
- Is the requested dose within FDA labeled dosing or is supported in approved compendium (i.e., AHFS, or DrugDex 1 or 2a level of evidence) for the requested indication. ☐ Yes ☐ No

  If no, has information been provided in support of therapy with a higher dose for the requested indication? ☐ Yes ☐ No

**Renewal Evaluation for Botulinum Toxin agents**

- Does the patient have a diagnosis of chronic migraine **AND** treatment with the requested agent has resulted in improvement in migraine prevention (e.g., reduced migraine headache days, reduced migraine frequency, reduced use of acute abortive migraine medication) with the requested agent? ☐ Yes ☐ No
- Is the prescriber a headache specialist (e.g., neurologist; pain management specialist; or specialist with United Council for Neurologic Subspecialties [UCNS] certification) or has consulted with a headache specialist? ☐ Yes ☐ No

- Does the patient have another diagnosis **AND** has had clinical stabilization/improvement with the requested agent? ☐ Yes ☐ No
- Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
- Is the requested dose within FDA labeled dosing or is supported in approved compendium (i.e., AHFS, or DrugDex 1 or 2a level of evidence) for the requested indication. ☐ Yes ☐ No

  If no, has information been provided in support of therapy with a higher dose for the requested indication? ☐ Yes ☐ No

***Include all applicable documentation for request.**

Please use a separate form for each drug.

To fill out form type or write using blue or black ink

**Please fax this form to: 1-866-805-4150**

Telephone: 1-800-471-2242

Prior authorization is not a guarantee of payment; benefits and eligibility will apply at the time of claim adjudication.