Botox

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

 Botox SGM -04/2020

Criteria Questions:

1. What is the diagnosis?
   - ❑ Blepharospasm
   - ❑ Cervical dystonia (e.g., torticollis)
   - ❑ Chronic migraine prophylaxis
   - ❑ Overactive bladder with urinary incontinence
   - ❑ Primary axillary, palmer, or gustatory (Frey's syndrome) hyperhidrosis
   - ❑ Strabismus
   - ❑ Upper limb spasticity
   - ❑ Lower limb spasticity
   - ❑ Urinary incontinence associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis)
   - ❑ Achalasia
   - ❑ Chronic anal fissures
   - ❑ Essential tremor
   - ❑ Excessive salivation (chronic sialorrhea)
   - ❑ Hemifacial spasm
   - ❑ Spasmodic dysphonia (laryngeal dystonia)
   - ❑ Oromandibular dystonia
   - ❑ Myofascial pain syndrome
   - ❑ Focal hand dystonia
   - ❑ Facial myokymia
   - ❑ Hirschsprung disease with internal sphincter achalasia
   - ❑ Orofacial tardive dyskinesia
   - ❑ Painful bruxism
   - ❑ Palatal myoclonus
   - ❑ First bite syndrome
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Is therapy prescribed for cosmetic purposes (e.g., treatment of wrinkles or uncorrected congenital strabismus and no binocular fusion)? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Chronic Migraine Prophylaxis

4. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #6*

5. Has the patient achieved or maintained a reduction in monthly headache frequency since starting therapy with Botox? ❑ Yes ❑ No *No further questions*

6. Prior to initiating therapy, how many days per month does (did) the patient experience headaches? _____ days

7. How many hours does (did) the patient's headache last? _____ hours

8. Has the patient completed an adequate trial of three oral migraine preventative therapies coming from at least 2 of the following classes: ❑ Yes ❑ No
   a) Antidepressants (e.g., amitriptyline, nortriptyline, venlafaxine)
   b) Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium)
   c) Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)
   d) Calcium channel blockers (e.g., amlodipine, diltiazem, felodipine)

9. How many days was the trial of each medication? _____ days

10. How many of the following applies to the patient's headache? _____
    a) Aggravated by routine movement
    b) Moderate to severe pain intensity
    c) Pulsating
    d) Unilateral

11. How many of the following symptoms applies to the patient's headache? _____
    a) Nausea/vomiting
    b) Sensitivity to light
    c) Sensitivity to sound

Section B: Cervical Dystonia

12. Prior to initiating therapy with Botox, was/is there sustained head torsion and/or tilt with limited range of motion with the patient's cervical dystonia? ❑ Yes ❑ No

Section C: Overactive Bladder with Urinary Incontinence

13. Prior to initiating therapy with Botox - along with urinary incontinence, does (did) the patient experience urgency and frequency? ❑ Yes ❑ No

14. Has the patient tried and failed behavioral therapy? ❑ Yes ❑ No

15. Has the patient had an inadequate response or experienced intolerance to at least two anticholinergic medications (examples: Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin])? ❑ Yes ❑ No

Section D: Primary Axillary, Palmer, or Gustatory (Frey's Syndrome) Hyperhidrosis

16. Has significant disruption of professional and/or social life occurred because of excessive sweating?
    ❑ Yes ❑ No

17. Has the patient tried topical aluminum chloride or other extra-strength antiperspirants?
    ❑ Yes ❑ No

18. Was the topical aluminum chloride or other extra-strength antiperspirant ineffective or result in a severe rash?
    ❑ Yes ❑ No

19. Is the patient unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anticholinergics, beta-blockers, or benzodiazepines)? ❑ Yes ❑ No

Section E: Strabismus

20. Is interference with the patient's normal visual system likely to occur? ❑ Yes ❑ No

21. Is the patient likely to have spontaneous recovery? ❑ Yes ❑ No

Section F: Urinary Incontinence Associated with a Neurologic Condition

22. Has the patient tried and failed behavioral therapy? ❑ Yes ❑ No

23. Has the patient had an inadequate response or experienced intolerance to an anticholinergic medication (examples: Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin])? ❑ Yes ❑ No

Section G: Achalasia

24. Has the patient tried and failed conventional therapy such as pneumatic dilation and surgical myotomy?
    ❑ Yes ❑ No

Section H: Chronic Anal Fissures

25. Has the patient failed to respond to first line therapy for chronic anal fissures such as topical calcium channel blockers or topical nitrates? ❑ Yes ❑ No

Section I: Excessive Salivation

26. Is the patient refractory to pharmacotherapy (for example, anticholinergics)? ❑ Yes ❑ No

Section J: Myofascial Pain Syndrome

27. How many of the following treatments has the patient tried and failed for myofascial pain syndrome? _____
    a) Physical therapy
    b) Injection of local anesthetics into trigger points
    c) Injection of corticosteroids into trigger points

Section K: Hirschsprung Disease with Internal Sphincter Achalasia

28. Is the patient's Hirschsprung disease with internal sphincter achalasia following endorectal pull through? ❑ Yes ❑ No

29. Is the patient refractory to laxative therapy? ❑ Yes ❑ No

Section L: Orofacial Tardive Dyskinesia

30. Has the patient tried and failed conventional therapies for orofacial tardive dyskinesia (examples: benzodiazepines, clozapine, or tetrabenazine)? ❑ Yes ❑ No

Section M: Painful Bruxism

31. Did the patient try and have an inadequate response to a night guard? ❑ Yes ❑ No

32. Did the patient have an inadequate response to pharmacotherapy such as diazepam? ❑ Yes ❑ No

Section N: Palatal Myoclonus

33. Prior to initiating therapy with Botox - does (did) the patient have disabling symptoms (for example, intrusive clicking tinnitus)? ❑ Yes ❑ No

34. Did the patient have an inadequate response to clonazepam, lamotrigine, carbamazepine, or valproate? ❑ Yes ❑ No

Section O: First Bite Syndrome

35. Has the patient failed to experience relief from analgesics, antidepressants, or anticonvulsants? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720