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* ❑ *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

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Criteria Questions:

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

❒ Yes, *No further questions*

❒ No, *Continue to #2*

2. What is the diagnosis?

❒ Blepharospasm, *Continue to #180*

❒ Cervical dystonia (e.g., torticollis), *Continue to #170*

❒ Chronic migraine prophylaxis, *Continue to #3*

❒ Overactive bladder with urinary incontinence, *Continue to #30*

❒ Primary axillary, palmar, or gustatory (Frey's syndrome) hyperhidrosis, *Continue to #40*

❒ Strabismus, *Continue to #50*

❒ Upper limb spasticity, *Continue to #160*

❒ Lower limb spasticity, *Continue to #160*

❒ Urinary incontinence associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis), *Continue to #60*

❒ Achalasia, *Continue to #70*

❒ Chronic anal fissures, *Continue to #80*

❒ Essential tremor, *Continue to #190*

❒ Excessive salivation (chronic sialorrhea, ptyalism), *Continue to #90*

❒ Hemifacial spasm, *Continue to #200*

❒ Spasmodic dysphonia (laryngeal dystonia), *Continue to #210*

❒ Oromandibular dystonia, *Continue to #220*

❒ Myofascial pain syndrome, *Continue to #100*

❒ Focal hand dystonia, *Continue to #230*

❒ Facial myokymia, *Continue to #240*

❒ Hirschsprung disease with internal sphincter achalasia, *Continue to #110*

❒ Orofacial tardive dyskinesia, *Continue to #120*

❒ Painful bruxism, *Continue to #130*

❒ Palatal myoclonus, *Continue to #140*

❒ First bite syndrome, *Continue to #150*

❒ Other

3. Is this request for continuation of therapy?

❒ Yes, *Continue to #4*

❒ No, *Continue to #10*

4. Is the requested medication prescribed by or in consultation with a neurologist?

❒ Yes, *Continue to #5*

❒ No, *Continue to #5*

5. What is the patient's age?

❒ 18 years of age or older, *Continue to #6*

❒ Less than 18 years of age, *Continue to #6*

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6. Will dosing exceed a cumulative dose of 400 units every 90 days?

❒ Yes, *Continue to #7*

❒ No, *Continue to #7*

7. Has the patient achieved or maintained a reduction in monthly headache frequency since starting therapy with the requested drug?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

10. Prior to initiating therapy, how many days per month does (did) the patient experience headaches?
_____(days/month) *Continue to #11*

11. Do (did) the patient's headaches last 4 hours or longer on at least 8 days per month?

❒ Yes, *Continue to #12*

❒ No *Continue to #12*

12. Has the patient completed an adequate trial of 2 oral migraine preventative therapies coming from at least 2 of the following classes?

- Antidepressants (e.g., amitriptyline, venlafaxine)
- Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium)
- Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)

❒ Yes, *Continue to #15*
❒ No, *Continue to #13*

13. Does the patient have a contraindication to any of the following classes?

- Antidepressants (e.g., amitriptyline, venlafaxine)
- Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium)
- Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)

❒ Yes, *Continue to #14*

❒ No, *Continue to #14*

14. How many of the following classes does the patient have a contraindication to?

- Antidepressants (e.g., amitriptyline, venlafaxine)
- Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium)
- Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)

❒ One class, *Continue to #17*

❒ Two classes, *Continue to #17*

15. How many of the following classes has the patient had an adequate trial?

- Antidepressants (e.g., amitriptyline, venlafaxine)
- Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium)
- Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)

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❒ One class, *Continue to #16*

❒ Two classes, *Continue to #16*

16. How many days was the trial of each medication? _____ days, *Continue to #17*

17. Does the patient have signs and symptoms consistent with chronic migraine criteria as defined by the International Headache Society (IHS)?

❒ Yes, *Continue to #18*

❒ No, *Continue to #18*

18. Is the requested medication prescribed by or in consultation with a neurologist?

❒ Yes, *Continue to #19*

❒ No, *Continue to #19*

19. What is the patient's age?

❒ 18 years of age or older, *Continue to #20*

❒ Less than 18 years of age, *Continue to #20*

20. Will dosing exceed a cumulative dose of 400 units every 90 days?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

30. Prior to initiating therapy with the requested drug - along with urinary incontinence, does (did) the patient experience urgency and frequency?

❒ Yes, *Continue to #31*

❒ No, *Continue to #31*

31. Has the patient tried and failed behavioral therapy?

❒ Yes, *Continue to #32*

❒ No, *Continue to #32*

32. Has the patient had an inadequate response or experienced intolerance to at least two agents from either of the following classes?

- Anticholinergic drugs (examples: Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin])
- Beta-3 adrenergic agonist (e.g., Myrbetriq [miraberon], Gemtesa [vibegron])

❒ Yes, *Continue to #33*

❒ No, *Continue to #33*

33. Is the requested medication prescribed by or in consultation with a neurologist or urologist?

❒ Yes, *Continue to #34*

❒ No, *Continue to #34*

34. What is the patient's age?

❒ 18 years of age or older, *Continue to #35*

❒ Less than 18 years of age, *Continue to #35*

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35. Will dosing exceed a cumulative dose of 400 units every 90 days?

❒ Yes, *Continue to #600*

❒ No, *Continue to #600*

40. Has significant disruption of professional and/or social life occurred because of excessive sweating?

❒ Yes, *Continue to #41*

❒ No, *Continue to #41*

41. Has the patient tried topical aluminum chloride or other extra-strength antiperspirants?

❒ Yes, *Continue to #42*

❒ No, *Continue to #42*

42. Was the topical aluminum chloride or other extra-strength antiperspirant ineffective or result in a severe rash?

❒ Yes, *Continue to #43*

❒ No, *Continue to #43*

43. Is the requested medication prescribed by or in consultation with a neurologist, or dermatologist?

❒ Yes, *Continue to #44*

❒ No, *Continue to #44*

44. What is the patient's age?

❒ 18 years of age or older, *Continue to #45*
❒ Less than 18 years of age, *Continue to #45*

45. Will dosing exceed a cumulative dose of 400 units every 90 days?

❒ Yes, *Continue to #600*

❒ No, *Continue to #600*

50. Is interference with the patient's normal visual system likely to occur? Note: Strabismus repair is considered cosmetic in adults with uncorrected congenital strabismus and no binocular fusion

❒ Yes, *Continue to #51*

❒ No, *Continue to #51*

51. Is the patient likely to have spontaneous recovery?

❒ Yes, *Continue to #52*

❒ No, *Continue to #52*

52. Is the requested drug prescribed by or in consultation with a neurologist or ophthalmologist?

❒ Yes, *Continue to #53*

❒ No, *Continue to #53*

53. Is the patient 12 years of age or older?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

❒ g., spinal cord injury, multiple sclerosis)

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60. Has the patient tried and failed behavioral therapy?

❒ Yes, *Continue to #61*

❒ No, *Continue to #61*

61. Has the patient had an inadequate response or experienced intolerance to one agent from either of the following classes?

- Anticholinergic drugs (examples: Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin])
- Beta-3 adrenergic agonist (e.g., Myrbetriq [miraberon]

❒ Yes, *Continue to #62*

❒ No, *Continue to #62*

62. Is the requested medication prescribed by or in consultation with a neurologist or urologist?

❒ Yes, *Continue to #63*

❒ No, *Continue to #63*

63. Is the patient 5 years of age or older?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

70. Has the patient tried and failed or is a poor candidate for conventional therapy such as pneumatic dilation and surgical myotomy?

❒ Yes, *Continue to #71*
❒ No, *Continue to #71*

71. Is the requested medication prescribed by or in consultation with a gastroenterologist, proctologist, or colorectal surgeon?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

80. Has the patient failed to respond to first line therapy for chronic anal fissures such as topical calcium channel blockers or topical nitrates?

❒ Yes, *Continue to #81*

❒ No, *Continue to #81*

81. Is the requested drug prescribed by or in consultation with a gastroenterologist, proctologist, or colorectal surgeon?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

90. Is the patient refractory to pharmacotherapy (e.g., anticholinergics)?

❒ Yes, *Continue to #91*

❒ No, *Continue to #91*

91. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

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100. How many of the following treatments has the patient tried and failed for myofascial pain syndrome?

- Physical therapy
- Injection of local anesthetics into trigger points
- Injection of corticosteroids into trigger points

❒ Less than 3 treatments, *Continue to #101*

❒ 3 treatments, *Continue to #101*

101. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

110. Has the patient undergone an endorectal pull through to treat Hirschsprung disease with internal sphincter achalasia?

❒ Yes, *Continue to #111*

❒ No, *Continue to #111*

111. Is the patient refractory to laxative therapy?

❒ Yes, *Continue to #112*

❒ No, *Continue to #112*

112. Is the requested medication prescribed by or in consultation with a gastroenterologist, proctologist, or colorectal

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

120. Has the patient tried and failed conventional therapies for orofacial tardive dyskinesia (e.g., benzodiazepines, clozapine, or tetrabenazine)?

❒ Yes, *Continue to #121*

❒ No, *Continue to #121*

121. Is the requested medication prescribed by or in consultation with a neurologist?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

130. Did the patient try and have an inadequate response to a night guard?

❒ Yes, *Continue to #131*

❒ No, *Continue to #131*

131. Did the patient have an inadequate response to pharmacotherapy such as diazepam?

❒ Yes, *Continue to #132*

❒ No, *Continue to #132*

132. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

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140. Prior to initiating therapy with the requested drug - does (did) the patient have disabling symptoms (for example,

❒ Yes, *Continue to #141*

❒ No, *Continue to #141*

141. Did the patient have an inadequate response to clonazepam, lamotrigine, carbamazepine, or valproate?

❒ Yes, *Continue to #142*

❒ No, *Continue to #142*

142. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

150. Has the patient failed to experience relief from analgesics, antidepressants, or anticonvulsants?

❒ Yes, *Continue to #151*

❒ No, *Continue to #151*

151. Is the requested medication prescribed by or in consultation with a neurologist or oncologist?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

160. Does the patient have a primary diagnosis of upper or lower limb spasticity or a symptom of a condition causing limb spasticity (including focal spasticity or equinus gait due to cerebral palsy)?

❒ Yes, *Continue to #161*
❒ No, *Continue to #161*

161. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?

❒ Yes, *Continue to #162*

❒ No, *Continue to #162*

162. Is the patient 2 years of age or older?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

170. Prior to initiating therapy with the requested drug, was/is there abnormal placement of the head with limited range of motion in the neck?

❒ Yes, *Continue to #171*

❒ No, *Continue to #171*

171. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?

❒ Yes, *Continue to #172*

❒ No, *Continue to #172*

172. What is the patient's age?

❒ 18 years of age or older, *Continue to #173*

❒ Less than 18 years of age, *Continue to #173*

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173. Will dosing exceed a cumulative dose of 400 units every 90 days?

❒ Yes, *Continue to #600*

❒ No, *Continue to #600*

180. Has the patient been diagnosed with blepharospasm, including blepharospasm associated with dystonia, benign essential blepharospasm or VII nerve disorder?

❒ Yes, *Continue to #181*

❒ No, *Continue to #181*

181. Is the requested medication prescribed by or in consultation with a neurologist or ophthalmologist?

❒ Yes, *Continue to #182*

❒ No, *Continue to #182*

182. Is the patient 12 years of age or older?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

190. Is the requested medication prescribed by or in consultation with a neurologist?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

200. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?

❒ Yes, *Continue to #500*
❒ No, *Continue to #500*

210. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

220. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

230. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

240. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?

❒ Yes, *Continue to #500*

❒ No, *Continue to #500*

500. What is the patient's age?

❒ 18 years of age or older, *Continue to #501*

❒ Less than 18 years of age, *Continue to #502*

501. Will dosing exceed a cumulative dose of 400 units every 90 days?

❒ Yes, *Continue to #600*

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❒ No, *Continue to #600*

502. Will the dosing exceed the lessor of 10 units/kg or 340 units every 90 days?

❒ Yes, *Continue to 6500*

❒ No, *Continue to #600*

600. Is this request for continuation of therapy?

❒ Yes, *Continue to #601*

❒ No, *No Further Questions*

601. Was the requested drug effective for treating the diagnosis or condition?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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

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