HIGHMARK HEALTH OPTIONS

Updated: 07/2024
Approved: 07/2024

Request for Prior Authorization for Botulinum Toxins Name
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Botulinum Toxins require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Botulinum Toxins Prior Authorization Criteria:

For all requests the following criteria must be met in addition to the diagnosis specific criteria below:

- Must have a therapeutic failure, contraindication, or intolerance to Dysport and Xeomin when FDA-approved or medically accepted for the member's diagnosis.
- Must be prescribed for an FDA-approved or medically accepted indication
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines

Coverage may be provided with a diagnosis of **axillary hyperhidrosis** and the following criteria is met:

- There is documentation that the axillary hyperhidrosis is severe, intractable and disabling in nature as documented by:
    - 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%

Coverage may be provided with a diagnosis of **strabismus** or **blepharospasm associated with dystonia**, including benign essential blepharospasm or VII nerve disorder

Coverage may be provided with a diagnosis of **cervical dystonia (spasmodic torticollis)**

Coverage may be provided with a diagnosis of **chronic migraine** as prophylaxis and the following criteria is met:

- The member has at least 15 headache days per month for at least 3 months with headache lasting at least four hours per day

- Must provide documentation showing the member has tried and failed for at least 2 months (at optimal or maximum tolerated dose) or had an intolerance or contraindication to at least three migraine prophylaxis agents (e.g., topiramate, propranolol, metoprolol, divalproex, sodium valproate)
- The member has had a trial and failure of a preferred injectable antimigraine prophylaxis agent or submitted a clinical reason for not having a trial of a preferred agent

Coverage may be provided with a diagnosis of **urinary incontinence due to detrusor overactivity** associated with neurologic conditions (e.g. spinal cord injury, MS) OR **overactive bladder (OAB)** with symptoms of urge urinary incontinence, urgency, and frequency and the following criteria is met:

- Must provide documentation showing the member has tried and failed or had an intolerance or contraindication to two anticholinergic medication (e.g., solifenacin, oxybutynin)

Coverage may be provided with the diagnosis of **spasticity** and the following criteria is met:

- Must meet one of the following:
  - Spasticity interferes with activities of daily living
  - Spasticity is expected to result in joint contracture with future growth

Initial Duration of Approval: 12 months

Reauthorization criteria:

- Documentation of clinical benefit and tolerance to therapy.

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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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BOTULINUM TOXINS 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: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 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:

For chronic migraine prophylaxis:

- Does the member have headaches occurring on 15 or more days a month for at least 3 months? ☐ Yes ☐ No
- Do the headaches last at least 4 hours per day? ☐ Yes ☐ No
- Has the member tried 3 migraine prophylaxis agents? ☐ Yes, please list below ☐ No

For axillary hyperhidrosis:

- Is the hyperhidrosis severe, intractable and disabling? ☐ Yes ☐ No
- Has topical aluminum chloride 20% been tried for at least two months? ☐ Yes ☐ No

For urinary incontinence associated with neurologic conditions OR overactive bladder:

- Has the member tried 2 anticholinergic medications? ☐ Yes, please list below ☐ No

For spasticity:

- Does it interfere with daily living OR expected to result in joint contracture with future growth? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Is there documentation of clinical benefit and tolerance to therapy? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date