Botox

CareFirst 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*

What is the ICD-10 code? _____

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

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CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Exception Criteria Questions:

A. The preferred products for your patient's health plan are Dysport and Xeomin. Can the patient's treatment be switched to one of the preferred products?

❒ Yes, *Please obtain Form for preferred product and submit for corresponding PA.*

❒ No, *Continue to Question B*

B. What is the patient's diagnosis? ***Action required****: If 'None of the above', attach supporting chart note(s) indicating diagnosis*

❒ Spasticity, *Skip to Question D*

❒ Cervical dystonia, *Continue to Question C*

❒ Blepharospasm, *Skip to Question D*

❒ None of the above, *Skip to Criteria Questions*

C. Is the patient 18 years of age or older?

❒ Yes, *Continue to Question D*

❒ No, *Skip to Criteria Questions*

D. Did the patient have a documented inadequate response, intolerable adverse event, or contraindication to all preferred products (Dysport and Xeomin)? ***Action Required****: If 'Yes', attach supporting chart note(s)*

❒ Yes ❑ No, *If Yes or No, Continue to Criteria Questions*

Criteria Questions:

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

❒ Yes, *Continue to 2*

❒ No, *Continue to 2*

2. What is the diagnosis?

❒ Blepharospasm, *Continue to 67*

❒ Cervical dystonia (e.g., torticollis), *Continue to 63*

❒ Chronic migraine prophylaxis, *Continue to 3*

❒ Overactive bladder with urinary incontinence, *Continue to 19*

❒ Primary axillary, palmar, or gustatory (Frey's syndrome) hyperhidrosis, *Continue to 25*

❒ Strabismus, *Continue to 31*

❒ Upper limb spasticity, *Continue to 60*

❒ Lower limb spasticity, *Continue to 60*

❒ Urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis), *Continue to 35*

❒ Achalasia, *Continue to 39*

❒ Chronic anal fissures, *Continue to 41*

❒ Essential tremor, *Continue to 70*

❒ Excessive salivation (chronic sialorrhea, ptyalism), *Continue to 43*

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❒ Hemifacial spasm, *Continue to 71*

❒ Spasmodic dysphonia (laryngeal dystonia), *Continue to 72*

❒ Oromandibular dystonia, *Continue to 73*

❒ Myofascial pain syndrome, *Continue to 45*

❒ Focal hand dystonia, *Continue to 74*

❒ Facial myokymia, *Continue to 75*

❒ Hirschsprung disease with internal sphincter achalasia, *Continue to 47*

❒ Orofacial tardive dyskinesia, *Continue to 50*

❒ Painful bruxism, *Continue to 52*

❒ Palatal myoclonus, *Continue to 55*

❒ First bite syndrome, *Continue to 58*

❒ Other, please specify. _____, *No further questions*

3. Is this request for continuation of therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 8*

4. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ 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*

6. Will the cumulative dosing used for one or more indications exceed 400 units every 84 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*

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

_____days, *Continue to 9*

9. Do (did) the patient's headaches last 4 hours or longer on at least 8 days per month?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

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10. Has the patient completed an adequate trial of 2 migraine preventative therapies coming from at least 2 of the following classes: a) Antidepressants (e.g., amitriptyline, venlafaxine), b) Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), c) Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol) or d) Calcitonin gene-related peptide (CGRP)-targeting therapies (e.g., fremanezumab, galcanezumab, eptinezumab, rimegepant, atogepant)?
❒ Yes, *Continue to 12*
❒ No, *Continue to 11*

11. Does the patient have a contraindication to any of the following classes: a) Antidepressants (e.g., amitriptyline, venlafaxine), b) Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), c) Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), or d) Calcitonin gene-related peptide (CGRP)-targeting therapies (e.g., fremanezumab, galcanezumab, eptinezumab, rimegepant, atogepant)?
❒ Yes, *Continue to 13*
❒ No, *Continue to 15*

12. How many of the following classes has the patient had an adequate trial: a) Antidepressants (e.g., amitriptyline, venlafaxine), b) Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), c) Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), or d) Calcitonin gene-related peptide (CGRP)-targeting therapies (e.g., fremanezumab, galcanezumab, eptinezumab, rimegepant, atogepant)?

❒ One class, *Continue to 15*

❒ Two or more classes, *Continue to 14*

13. How many of the following classes does the patient have a contraindication to: a) Antidepressants (e.g., amitriptyline, venlafaxine), b) Antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), c) Beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol), or d) Calcitonin gene-related peptide (CGRP)-targeting therapies (e.g., fremanezumab, galcanezumab, eptinezumab, rimegepant, atogepant)?

❒ One class, *Continue to 15*

❒ Two or more classes, *Continue to 15*

14. How many days was the trial of each drug?

_____days, *Continue to 15*

15. Does the patient have signs and symptoms consistent with chronic migraine criteria as defined by the International Headache Society (IHS)?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. What is the patient's age?

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

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

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18. Will the cumulative dosing used for one or more indications exceed 400 units every 84 days?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

19. Prior to initiating therapy with the requested drug - along with urinary incontinence, does (did) the patient experience urgency and frequency?
❒ Yes, *Continue to 20*
❒ No, *Continue to 20*

20. Has the patient tried and failed behavioral therapy?
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Has the patient had an inadequate response or experienced intolerance to at least two agents from either of the following classes: a) Anticholinergic drugs (e.g., Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin]), b) Beta-3 adrenergic agonist (e.g., Myrbetriq [mirabegron], Gemtesa [vibegron])?
❒ Yes, *Continue to 22*
❒ No, *Continue to 22*

22. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. What is the patient's age?
❒ 18 years of age or older, *Continue to 24*
❒ Less than 18 years of age, *Continue to 24*

24. Will the cumulative dosing used for one or more indications exceed 400 units every 84 days?
❒ Yes, *Continue to 79*
❒ No, *Continue to 79*

25. Has significant disruption of professional and/or social life occurred because of excessive sweating?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Has the patient tried topical aluminum chloride or other extra-strength antiperspirants?
❒ Yes, *Continue to 27*
❒ No, *Continue to 28*

27. Was the topical aluminum chloride or other extra-strength antiperspirant ineffective or result in a severe rash?
❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

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29. What is the patient's age?

❒ 18 years of age or older, *Continue to 30*

❒ Less than 18 years of age, *Continue to 30*

30. Will the cumulative dosing used for one or more indications exceed 400 units every 48 days?

❒ Yes, *Continue to 79*

❒ No, *Continue to 79*

31. 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 32*

❒ No, *Continue to 32*

32. Is the patient likely to have spontaneous recovery?

❒ Yes, *Continue to 33*

❒ No, *Continue to 33*

33. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?

❒ Yes, *Continue to 34*

❒ No, *Continue to 34*

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

❒ Yes, *Continue to 76*

❒ No, *Continue to 76*

35. Has the patient tried and failed behavioral therapy?

❒ Yes, *Continue to 36*

❒ No, *Continue to 36*

36. Has the patient had an inadequate response or experienced intolerance to one agent from either of the following classes: a) Anticholinergic drugs (e.g., Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin]), b) Beta-3 adrenergic agonist (e.g., Myrbetriq [mirabegron])?

❒ Yes, *Continue to 37*

❒ No, *Continue to 37*

37. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?

❒ Yes, *Continue to 38*

❒ No, *Continue to 38*

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

❒ Yes, *Continue to 76*

❒ No, *Continue to 76*

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39. Has the patient tried and failed or is a poor candidate for conventional therapy such as pneumatic dilation and surgical myotomy?
❒ Yes, *Continue to 40*
❒ No, *Continue to 40*

40. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

41. 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 42*
❒ No, *Continue to 42*

42. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

43. Is the patient refractory to pharmacotherapy (e.g., anticholinergics)?
❒ Yes, *Continue to 44*
❒ No, *Continue to 44*

44. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

45. Has the patient tried and failed all of the following for the treatment of myofascial pain syndrome: a) Physical therapy, b) Injection of local anesthetics into trigger points, c) Injection of corticosteroids into trigger points?
❒ Yes, *Continue to 46*
❒ No, *Continue to 46*

46. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

47. Has the patient undergone an endorectal pull through to treat Hirschsprung disease with internal sphincter achalasia?
❒ Yes, *Continue to 48*
❒ No, *Continue to 48*

48. Is the patient refractory to laxative therapy?
❒ Yes, *Continue to 49*
❒ No, *Continue to 49*

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49. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

50. Has the patient tried and failed conventional therapies for orofacial tardive dyskinesia (e.g., benzodiazepines, clozapine, or tetrabenazine)?
❒ Yes, *Continue to 51*
❒ No, *Continue to 51*

51. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

52. Did the patient try and have an inadequate response to a night guard?
❒ Yes, *Continue to 53*
❒ No, *Continue to 53*

53. Did the patient have an inadequate response to pharmacotherapy such as diazepam?
❒ Yes, *Continue to 54*
❒ No, *Continue to 54*

54. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

55. Prior to initiating therapy with the requested drug, does (did) the patient have disabling symptoms (for example, intrusive clicking tinnitus)?
❒ Yes, *Continue to 56*
❒ No, *Continue to 56*

56. Did the patient have an inadequate response to clonazepam, lamotrigine, carbamazepine, or valproate?
❒ Yes, *Continue to 57*
❒ No, *Continue to 57*

57. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

58. Has the patient failed to experience relief from analgesics, antidepressants, or anticonvulsants?
❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

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59. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

60. Does the patient have a primary diagnosis of upper or lower limb spasticity or as a symptom of a condition causing limb spasticity (including focal spasticity or equinus gait due to cerebral palsy)?
❒ Yes, *Continue to 61*
❒ No, *Continue to 61*

61. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 62*
❒ No, *Continue to 62*

62. Is the patient 2 years of age or older?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

63. 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 64*
❒ No, *Continue to 64*

64. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 65*
❒ No, *Continue to 65*

65. What is the patient's age?

❒ 18 years of age or older, *Continue to 66*

❒ Less than 18 years of age, *No further questions*

66. Will the cumulative dosing used for one or more indications exceed 400 units every 84 days?
❒ Yes, *Continue to 79*
❒ No, *Continue to 79*

67. Has the patient been diagnosed with blepharospasm, including blepharospasm associated with dystonia, benign essential blepharospasm or VII nerve disorders?
❒ Yes, *Continue to 68*
❒ No, *Continue to 68*

68. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 69*
❒ No, *Continue to 69*

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69. Is the patient 12 years of age or older?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

70. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

71. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

72. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

73. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

74. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

75. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

76. What is the patient's age?

❒ 18 years of age or older, *Continue to 77*

❒ Less than 18 years of age, *Continue to 78*

77. Will the cumulative dosing used for one or more indications exceed 400 units every 84 days?
❒ Yes, *Continue to 79*
❒ No, *Continue to 79*

78. Will the total dose exceed the lessor of 10 units/kg or 340 units every 84 days?
❒ Yes, *Continue to 79*
❒ No, *Continue to 79*

79. Is this request for continuation of therapy?
❒ Yes, *Continue to 80*
❒ No, *No Further Questions*

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80. Was the requested drug effective for treating the diagnosis or condition?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

Step Therapy Override: Complete if Applicable for the state of Maryland.	Please Circle	
Is the requested drug being used to treat stage four advanced metastatic cancer?	Yes	No
Is the requested drug's use consistent with the FDA-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer and is supported by peer-reviewed medical literature?	Yes	No
Is the requested drug being used for an FDA-approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)?	Yes	No
Do patient chart notes document the requested drug was ordered with a paid claim at the pharmacy, the pharmacy filled the prescription and delivered to the patient or other documentation that the requested drug was prescribed for the patient in the last 180 days?	Yes	No
Has the prescriber provided proof documented in the patient chart notes that in their opinion the requested drug is effective for the patient's condition?	Yes	No

Step Therapy Override: Complete if Applicable for the state of Virginia.	Please Circle	
Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Yes	No
Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature?	Yes	No
Is the request for a brand drug that has an AB-rated generic equivalent or interchangeable biological product available?	Yes	No
Has the patient had a trial and failure of the AB-rated generic equivalent or interchangeable biological product due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Yes	No
Is the preferred drug contraindicated?	Yes	No
Is the preferred drug expected to be ineffective based on the known clinical characteristics of the patient and the prescription drug regimen?	Yes	No
Has the patient tried the preferred drug while on their current or previous health benefit plan and it was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?	Yes	No
Is the patient currently receiving a positive therapeutic outcome with the requested drug for their medical condition?	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

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