Dysport

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? _____

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?
❒ Cervical dystonia (e.g., torticollis), *Continue to 3*
❒ Upper limb spasticity, *Continue to 14*

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❒ Lower limb spasticity, *Continue to 14*
❒ Blepharospasm, including blepharospasm associated with dystonia and benign essential blepharospasm, *Continue to 17*
❒ Hemifacial spasm, *Continue to 18*
❒ Chronic anal fissures, *Continue to 6*
❒ Excessive salivation (chronic sialorrhea), *Continue to 8*
❒ Primary axillary hyperhidrosis, *Continue to 10*
❒ Other, please specify. _____, *No further questions*

3. 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 4*
❒ No, *Continue to 4*

4. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. What is the patient's age?
❒ 18 years of age or older, *Continue to 19*
❒ Less than 18 years of age, *Continue to 19*

6. 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 7*
❒ No, *Continue to 7*

7. Is the requested medication prescribed by or in consultation with a gastroenterologist, proctologist, or colorectal surgeon?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

8. Is the patient refractory to pharmacotherapy (e.g., anticholinergics)?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Is the requested drug prescribed by or in consultation with a neurologist or otolaryngologist?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

10. Has significant disruption of professional and/or social life occurred because of excessive sweating?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Has the patient tried topical aluminum chloride or other extra-strength antiperspirant?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

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

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

13. Is the requested medication prescribed by or in consultation with a neurologist, dermatologist, or internist?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

14. 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 15*
❒ No, *Continue to 15*

15. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Is the patient 2 years of age or older?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

17. Is the requested medication prescribed by or in consultation with a neurologist or ophthalmologist?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

18. Will the requested drug be prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is this request for continuation of therapy?
❒ Yes, *Continue to 20*
❒ No, *No Further Questions*

20. 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)**

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