Xeomin

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

 Xeomin SGM 2250-A – 01/2025.

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

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*
❒ Blepharospasm, including benign essential blepharospasm or blepharospasm associated with dystonia, *Continue to 13*

❒ Upper limb spasticity, *Continue to 9*

❒ Chronic sialorrhea (excessive salivation), *Continue to 6*

❒ 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 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 15*

❒ Less than 18 years of age, *Continue to 15*

6. Is the patient refractory to pharmacotherapy (e.g., anticholinergics)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. What is the patient's age?

❒ 2 years of age or older, *Continue to 15*

❒ Less than 2 years of age, *Continue to 15*

9. Is the spasticity the primary diagnosis or as a symptom of a condition causing limb spasticity?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. What is the patient's age?

❒ 18 years of age or older, *Continue to 12*

❒ Less than 18 years of age, *Continue to 11*

11. Is the patient a pediatric patient between the age of 2 and 17 and the spasticity is not caused by cerebral palsy?

❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

13. Is the requested drug being prescribed by or in consultation with a provider specialized in treating the patient's condition?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. What is the patient's age?

❒ 18 years of age or older, *Continue to 15*

❒ Less than 18 years of age, *Continue to 15*

15. Is this request for continuation of therapy?
❒ Yes, *Continue to 16*
❒ No, *No Further Questions*

16. 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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