

**Botox, Dysport, Xeomin
 Prior Authorization Request**

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

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 **1-866-814-5506**. 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.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Demographic Information:

Patient Weight: _____ *kg*
Patient Height: _____ *ft* _____ *inches*

Criteria Questions:

- Which drug is being prescribed?
 Botox (onabotulinumtoxinA)
 Dysport (abobotulinumtoxinA)
 Xeomin (incobotulinumtoxinA)
 Other _____

Indicate prescribed number of units per 12-week interval: _____

- What is the diagnosis?

<input type="checkbox"/> Chronic migraine prophylaxis	<input type="checkbox"/> Detrusor sphincter dyssynergia due to a spinal cord injury
<input type="checkbox"/> Primary axillary hyperhidrosis	<input type="checkbox"/> Dysphagia
<input type="checkbox"/> Spasticity	<input type="checkbox"/> Excessive salivation secondary to Parkinson's disease
<input type="checkbox"/> Overactive bladder with urinary incontinence	<input type="checkbox"/> Hemifacial spasm
<input type="checkbox"/> Achalasia	<input type="checkbox"/> Sphincter of Oddi dysfunction
<input type="checkbox"/> Blepharospasm	<input type="checkbox"/> Strabismus
<input type="checkbox"/> Cervical dystonia (e.g., torticollis)	<input type="checkbox"/> Oromandibular dystonia
<input type="checkbox"/> Chronic anal fissures	
<input type="checkbox"/> Spasmodic dysphonia (laryngeal dystonia)	
<input type="checkbox"/> Urinary incontinence associated with a neurologic condition (eg, spinal cord injury, multiple sclerosis)	
<input type="checkbox"/> Other _____	
- What is the ICD code? _____
- Is therapy prescribed for cosmetic purposes (eg, treatment of wrinkles)? Yes No

Complete the following section based on the patient's diagnosis.

Section A: Chronic Migraine Prophylaxis

- Is this request for renewal of therapy? Yes No *If No, skip to #7*

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6. Has the patient achieved or maintained a 50% reduction in monthly headache frequency since starting therapy?
 Yes No *No further questions*
7. Prior to initiating therapy, how many **days per month** does (did) the patient experience headaches? _____
8. Has the patient completed an adequate trial (greater than or equal to 8 weeks) of oral migraine preventative therapy?
If Yes, indicate below or mark "None of the above."
Action Required: Attach documentation (e.g., chart notes) of the oral migraine preventative therapy tried.
- | | |
|--|--|
| <input type="checkbox"/> Divalproex sodium (Depakote, Depakote ER) | <input type="checkbox"/> Venlafaxine (Effexor) |
| <input type="checkbox"/> Topiramate (Topamax) | <input type="checkbox"/> Atenolol/Metoprolol/Propranolol/Timolol/Nadolol |
| <input type="checkbox"/> Gabapentin (Neurontin) | <input type="checkbox"/> Nimodipine/Verapamil |
| <input type="checkbox"/> Amitriptyline (Elavil) | <input type="checkbox"/> Naproxen/other NSAID |
| <input type="checkbox"/> None of the above | <input type="checkbox"/> Other _____ |

Section B: Spasticity

9. Does the patient have upper limb spasticity? *If Yes, no further questions* Yes No
10. Does the patient have lower limb spasticity secondary to cerebral palsy, multiple sclerosis, stroke, or post-traumatic brain or spinal cord injury? Yes No

Section C: Urinary Incontinence / Overactive Bladder

11. Has the patient had an inadequate response to or is intolerant of an anticholinergic medication? 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)