PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Botulinum Toxin

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phone: _____ Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Is this provider a neurologist or physiatrist? ☐ Yes ☐ No

Product and Billing Information

☐ New request ☐ Continuation request

Drug product:

botulinum toxin type A
- ☐ Botox 100 unit vial
- ☐ Botox 200 unit vial
- ☐ Dysport 300 unit vial
- ☐ Dysport 300 unit vial
- ☐ Dysport 500 unit vial
- ☐ Xeomin 50 unit vial
- ☐ Xeomin 100 unit vial

botulinum toxin type B
- ☐ Myobloc 2,500 unit vial
- ☐ Myobloc 5,000 unit vial
- ☐ Myobloc 10,000 unit vial

Dose:_____ **Dose Frequency**:_____

Start date (or date of next dose): _____

Date of first dose:_____

Date of last dose: _____

Date of next dose: _____

Place of administration:
- ☐ Physician's office
- ☐ Outpatient infusion
  - Facility: _____ NPI:_____ Fax:_____
- ☐ Home infusion
  - Facility: _____ NPI:_____ Fax:_____

Billing:
- ☐ Physician to buy and bill
- ☐ Facility to buy and bill
- ☐ Specialty Pharmacy
  - Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 12/2018
Last reviewed 01/2019

Provide any additional information for consideration by Priority Health (see policy below for specific requirements):

BOTULINUM TOXIN COVERAGE POLICY

Precertification Requirements

Before botulinum toxin is covered, the patient must meet all of the requirements for the treatment diagnosis listed in this policy and the prescribe dose is within covered dosing limits. Priority Health only covers the diagnoses listed below in this policy. Priority Health may consider a diagnosis not listed in this policy to be not medically necessary and/or experimental and investigational. If the criteria outlined in this coverage policy are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.

The following diagnoses are covered if associated with spasticity or dystonia:

1. Blepharospasm
2. Cerebral palsy
3. Cervical dystonia
4. Demyelinating diseases of the CNS and copus callosum including Leukodystrophy
5. Esophageal achalasia
6. Facial nerve VII disorder *(facial myokymia, Melkersson's syndrome, facial/hemifacial spasms)*
7. Focal hand dystonia (i.e. organic writer's cramp)
8. Hereditary spastic paraplegia
9. Jaw-closing oromandibular dystonia
10. Laryngeal spasm, Laryngeal adductor spastic dysphonia or stradulus
11. Lingual dystonia
12. Multiple Sclerosis
13. Neuromyelitis optica
14. Orofacial dyskinesia
15. Schilder's disease
16. Spastic hemiplegia due to stroke or brain injury
17. Strabismus
18. Torsion dystonia, idiopathic and symptomatic
19. Torticollis

The following diagnoses are covered only if additional requirements for the diagnosis are satisfied:

1. **Anal fissures**
   Coverage for anal fissures is reserved for patients who remain symptomatic after 8 weeks of topical therapy with either nitroglycerin ointment or diltiazem and who decline, or are not candidates for, surgical intervention.

2. **Detrusor over activity associated with a neurologic condition**
   Coverage for detrusor over activity requires documentation of the underlying neurological condition that is the cause of detrusor activity (e.g. spinal cord injury or multiple sclerosis). In addition, the patient must have a therapeutic trial with an anticholinergic drug, which requires specific documentation of the trial(s) with the request for coverage. The recommended and maximum dose is 200 units intramuscularly for each treatment, once every 90 days.

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3. **Hyperhidrosis (HH)**
   Coverage is authorized for primary axillary or palmar HH. Plantar HH is not covered. For primary axillary HH, the patient must be unable to achieve satisfactory results using aluminum chloride (generic for Drysol) or other extra-strength (more than 20%) antiperspirants or be intolerant to these therapies because of severe rash. For palmar HH, the patient must be unable to achieve satisfactory results using aluminum chloride (generic for Drysol).

4. **Migraine (chronic)**
   Cluster, tension, and cervicogenic headaches are not a covered benefit. Chronic migraine means the patient's headaches are disabling and occur on 15 days or more each month, lasting four hours each day or longer. Coverage for prophylaxis of chronic migraine requires documentation to show the patient's condition meets Priority Health's definition of chronic migraine. . Before approval Priority Health requires member to have first tried three drugs from the following prophylactic treatment options: propranolol, amitriptyline, topiramate, or Valproic acid and its derivatives.

5. **Overactive bladder**
   Coverage for overactive bladder requires documentation of therapeutic trials with two or more anticholinergic drugs. The recommended and maximum dose is 100 units intramuscularly for each treatment, once every 90 days.

6. **Ptyalism/sialorrhea**
   The patient's condition must be refractory to pharmacotherapy. Coverage for ptyalism/sialorrhea requires documentation the patient has previously tried anticholinergic therapy.

Dosing and duration of therapy

If approved, authorization will be for one dose every 90 days for two years. It is usually not considered medically necessary to give botulinum toxin injection more frequently than every 90 days. An exception is for migraine prophylaxis, which will be authorized for one dose every 84 days. The maximum cumulative dose should generally not exceed 400 units in a 3 month interval when treating one or more indications. Requests exceeding 400 units in a 3-month interval must be explained by the provider and are subject to Priority Health's medical necessity review.

Non-covered services

The following conditions are not covered:

1. Botulinum toxin for the treatment of anal spasm, irritable colon, biliary dyskinesia, craniofacial wrinkles or any treatment of other spastic conditions not listed as covered on this prior authorization form are considered experimental (including the treatment of smooth muscle spasm).
2. Botulinum toxin for patients receiving aminoglycosides
3. Botulinum toxin for patients with chronic paralytic strabismus, except to reduce antagonistic contractor with surgical repair
4. Treatment exceeding accepted dosage parameters unless supported by individual medical record review as well as treatments where the goal is to improve appearance rather than function.
5. Use of botulinum toxin A or botulinum toxin B for all other conditions not listed as a covered benefit.

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