AvMed

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Botulinum Toxin Injections®, Type A

Drug Requested: Botox® (onabotulinumtoxinA) **(J0585)**
{For Upper Limb Spasticity (ULS) & Lower Limb Spasticity (LLS)}

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

☐ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

- **Cosmetic indications are EXCLUDED.**

NOTE: In treating adult patients for one or more indications, the maximum cumulative dose should not exceed 400 Units, in a 3-month interval. In pediatric patients, the total dose should not exceed the lower of 10 Units/kg body weight or 340 Units, in a 3-month interval.

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ **Single Arm Upper Limb Spasticity** **OR** ❑ **Both Arms Upper Limb Spasticity**
  - ❑ **Anterior Arm**
    - ❑ Biceps Brachii (100 – 200 units divided in 4 sites)
    - ❑ Flexor Carpi Radialis (12.5 - 50 units)
    - ❑ Flexor Carpi Ulnaris (12.5 – 50 units)
    - ❑ Flexor Pollicis Longus (20 units)
  - ❑ **Posterior Arm**
    - ❑ Flexor Digitorum Profundus (30-50 units)
    - ❑ Flexor Digitorum Sublimis (30-50 units)
- ❑ **Adductor Pollicis** (20 units)
- ❑ **Lower Limb Spasticity** (300 – 400 units divided among 5 muscles)
  - ❑ Gastrocnemius Medial Head (75 units)
  - ❑ Gastrocnemius Lateral Head (75 units)
  - ❑ Soleus (75 units)
  - ❑ Tibialis Posterior (75 units)
  - ❑ Flexor Halluces Longus (50 units)
  - ❑ Flexor Digitorum Longus (50 units)

Medication being provided by: Please check applicable box below.

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****
****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****