Botox

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

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Patient's Name: ______________________________ **Date**: __________________________________
Patient's ID: ________________________________ **Patient's Date of Birth:** __________________
Physician's Name: ____________________________ **NPI#:** ___________________________________
Specialty: ___________________________________ **HPHC Provider ID**_______________________
Physician Office Telephone: __________________ **Physician Office Fax:** _____________________

<u>Rendering</u> Provider Info: ❑ Same as Requesting Provider **HPHC Provider ID:**_______________________
Name: ____ **NPI#:** ______________________________
Fax: _____________________ **Phone:** __________________ **Provider Tax ID:** _________________________

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

<u>Additional Demographic Information:</u>

Please indicate the place of service for the requested drug:

❑ Ambulatory Surgical ❑ Home ❑ Inpatient Hospital ❑ Off Campus Outpatient Hospital
❑ On Campus Outpatient Hospital ❑ Office ❑ Pharmacy

<u>Drug Information:</u>

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

<u>Criteria Questions:</u>

1. What is the diagnosis?
   - ❑ Chronic migraine prophylaxis
   - ❑ Primary axillary hyperhidrosis
   - ❑ Strabismus
   - ❑ Hemifacial spasm
   - ❑ Achalasia
   - ❑ Blepharospasm
   - ❑ Cervical dystonia (e.g., torticollis)
   - ❑ Chronic anal fissures
   - ❑ Upper limb spasticity
   - ❑ Excessive salivation secondary to Parkinson's disease
   - ❑ Overactive bladder with urinary incontinence
   - ❑ Essential tremor
   - ❑ Spasmodic dysphonia (laryngeal dystonia)
   - ❑ Lower limb spasticity
   - ❑ Urinary incontinence associated with a neurologic condition (eg, spinal cord injury, multiple sclerosis)
   - ❑ Other ____
2. What is the ICD-10 code? _____________
3. Is therapy prescribed for cosmetic purposes (eg, treatment of wrinkles)? ❑ Yes ❑ No

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-844-851-0882

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Complete the following section based on the patient's diagnosis, if applicable.

<u>Section A: Chronic Migraine Prophylaxis</u>

4. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #6*
5. Has the patient achieved/maintained a 50% reduction in monthly headache frequency since starting therapy?
   ❑ Yes ❑ No *No further questions*
6. Prior to initiating therapy, how many ***days per month*** does (did) the patient experience headaches? _____________
7. Has the patient completed an adequate trial (greater than or equal to 8 weeks) of an oral migraine preventative therapy (e.g., divalproex sodium, topiramate, gabapentin, amitriptyline, venlafaxine, atenolol, metoprolol, propranolol, timolol, nadolol, nimodipine, verapamil, naproxen or other non-steroidal anti-inflammatory drugs [NSAIDs])?
   ❑ Yes ❑ No

<u>Section B: Urinary incontinence associated with a neurologic condition, Overactive Bladder with Urinary Incontinence</u>

8. Has the patient had an inadequate response to or is intolerant of an anticholinergic mediation? ❑ 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)**

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