CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Botox, Dyspot, Xeomin (for Maryland only)

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.

Additional Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*ft* _____*inches*

Criteria Questions:

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

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

2. What is the diagnosis?
   - ❑ Chronic migraine prophylaxis
   - ❑ Primary axillary hyperhidrosis
   - ❑ Spasticity
   - ❑ Overactive bladder with urinary incontinence
   - ❑ Achalasia
   - ❑ Blepharospasm
   - ❑ Cervical dystonia (e.g., torticollis)
   - ❑ Chronic anal fissures
   - ❑ Spasmodic dysphonia (laryngeal dystonia)
   - ❑ Detrusor sphincter dyssynergia due to a spinal cord injury
   - ❑ Dysphagia
   - ❑ Excessive salivation secondary to Parkinson's disease
   - ❑ Hemifacial spasm
   - ❑ Sphincter of Oddi dysfunction
   - ❑ Strabismus
   - ❑ Oromandibular dystonia
   - ❑ Urinary incontinence associated with a neurologic condition (eg, spinal cord injury, multiple sclerosis)
   - ❑ Other _____

3. What is the ICD code? _____

4. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #7*

5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days?
   ❑ Yes ❑ No ACTION REQUIRED: ***Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***

6. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #7 and complete this form in its entirety.*

7. 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

8. Is this request for renewal of therapy? ❑ Yes ❑ No *If No, skip to #10*

9. Has the patient achieved or maintained a 50% reduction in monthly headache frequency since starting therapy? ❑ Yes ❑ No *No further questions*

10. Prior to initiating therapy, how many ***days per month*** does (did) the patient experience headaches? _____

11. 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.

❑ Divalproex sodium (Depakote, Depakote ER)	❑ Venlafaxine (Effexor)
❑ Topiramate (Topamax)	❑ Atenolol/Metoprolol/Propranolol/Timolol/Nadolol
❑ Gabapentin (Neurontin)	❑ Nimodipine/Verapamil
❑ Amitriptyline (Elavil)	❑ Naproxen/other NSAID
❑ None of the above	❑ Other _____

Section B: Spasticity

12. Does the patient have upper limb spasticity? *If Yes, no further questions* ❑ Yes ❑ No

13. 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

14. 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)**