CareFirst
Family of health care plans

CVS/caremark

Botox

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. 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

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

Section A: Chronic migraine prophylaxis

4. Is this request for renewal 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

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 oral migraine preventative therapy?
   If Yes, indicate below or mark "None of the above"
   - ❑ Divalproex sodium (Depakote, Depakote ER)
   - ❑ Topiramate (Topamax)
   - ❑ Gabapentin (Neurontin)
   - ❑ Venlafaxine (Effexor)
   - ❑ Atenolol/Metoprolol/Propranolol/Timolol/Nadolol
   - ❑ Nimodipine/Verapamil

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❑ Amitriptyline (Elavil)
❑ Naproxen/other NSAID
❑ None of the above
❑ Other ___________________________________

Section B: Urinary incontinence associated with a neurologic condition OR Overactive bladder with urinary incontinence

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)**