Myobloc

Prior Authorization Request

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 **1-888-877-0518.** 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

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

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Clinical Criteria Questions:

1. What is thediagnosis?
   - ❑ Cervical dystonia (e.g., torticollis)
   - ❑ Primary axillary or palmer hyperhidrosis
   - ❑ Excessive salivation (chronic sialorrhea)
   - ❑ Upper limb spasticity
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Is therapy prescribed for cosmetic purposes (e.g., treatment of wrinkles)? ❑ Yes ❑ No

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

Section A: Cervical Dystonia

4. Is the patient an adult? ❑ Yes ❑ No

5. Prior to initiating therapy with Myobloc, was/is there abnormal placement of the head with limited range of motion in the neck? ❑ Yes ❑ No

Section B: Excessive Salivation

6. Is the patient refractory to pharmacotherapy (for example, anticholinergics)? ❑ Yes ❑ No

Section C: Primacy Axillary or Palmer Hyperhidrosis

7. Has significant disruption of professional and/or social life occurred because of excessive sweating? ❑ Yes ❑ No

8. Has the patient tried topical aluminum chloride or other extra-strength antiperspirants? ❑ Yes ❑ No

9. Was the topical aluminum chloride or other extra-strength antiperspirants ineffective or result in a severe rash? ❑ Yes ❑ No

10. Is the patient unresponsive or unable to tolerate oral pharmacotherapy prescribed for excessive sweating (e.g., anticholinergics, beta-blockers, or benzodiazepines)? ❑ Yes ❑ No

Section D: Upper Limb Spasticity

11. Is the spasticity a primary diagnosis or a symptom of a condition causing limb spasticity? ❑ 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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