Xeomin

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.

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* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Exception Criteria Questions (ECQ):

A. The preferred products for your patient's health plan are Botox and Dysport. Can the patient's treatment be switched to one of the preferred products?
❑ Yes, *Please obtain Form for preferred product and submit for corresponding PA*.
❑ No

B. Is this request for continuation of therapy with the requested product?
❑ Yes ❑ No, *skip ECQ D*

C. Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer 'Yes' ❑ Yes ❑ No, *skip to Criteria Questions*

D. Has the patient had a documented inadequate response or intolerable adverse event to treatment with both preferred products? **Action Required: *If yes, please attach supporting chart note(s).***
❑ Yes, *skip to Criteria Questions* ❑ No

E. Is the patient requesting Xeomin for the treatment of chronic sialorrhea? ❑ Yes, *skip to Criteria Questions* ❑ No

F. Is the patient requesting Xeomin for the treatment of blepharospasm? ❑ Yes ❑ No

G. Has the patient had a documented inadequate response to treatment with the preferred product (Botox)? **Action Required: *If yes, please attach supporting chart note(s).*** ❑ Yes, *skip to Criteria Questions* ❑ No

H. Has the patient experienced a documented intolerable adverse event to treatment with the preferred product (Botox)? **Action Required: *If yes, please attach supporting chart note(s).*** ❑ Yes ❑ No

Criteria Questions:

1. What is the diagnosis?
❑ Upper limb spasticity
❑ Blepharospasm
❑ Cervical dystonia (e.g., torticollis)
❑ Chronic sialorrhea
❑ Other _____

2. What is the ICD-10 code? _____

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

4. *If diagnosis is blepharospasm,* has the member been previously treated with onabotulinumtoxinA?
❑ Yes ❑ No

Step Therapy Override: Complete if Applicable.	Please Circle	
Would the prescriber like to request an override of the step therapy requirement?	Yes	No
Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ***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.)***	Yes	No
Is the medication effective in treating the member's condition?	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)**