Xeomin

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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Xeomin SGM – 02/2023.

Criteria Questions:

What is the ICD-10 code? _____________

1. Is therapy prescribed for cosmetic purposes (e.g., treatment of wrinkles or uncorrected congenital strabismus and no binocular fusion)?

❒ Yes, *Continue to #2*

❒ No, *Continue to #2*

2. What is the diagnosis?

❒ Cervical dystonia (e.g., torticollis), *Continue to #10*

❒ Blepharospasm, including blepharospasm associated with dystonia or benign essential blepharospasm, *Continue to #40*

❒ Upper limb spasticity, *Continue to #30*

❒ Chronic sialorrhea (excessive salivation), *Continue to #20*

❒ Other, *No Further Questions*

10. Prior to initiating therapy with the requested drug, was/is there abnormal placement of the head with limited range of motion in the neck?

❒ Yes, *Continue to #11*

❒ No, *Continue to #11*

11. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?

❒ Yes, *Continue to #12*

❒ No, *Continue to #12*

12. What is the patient's age?

❒ 18 years of age or older, *Continue to #100*

❒ Less than 18 years of age, *Continue to #100*

20. Is the patient refractory to pharmacotherapy (e.g., anticholinergics)?

❒ Yes, *Continue to #21*

❒ No, *Continue to #21*

21. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?

❒ Yes, *Continue to #22*

❒ No, *Continue to #22*

22. What is the patient's age?

❒ 2 years of age or older, *Continue to #100*

❒ Less than 2 years of age, *Continue to #100*

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

❒ Yes, *Continue to #31*

❒ No, *Continue to #31*

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31. What is the patient's age?

❒ 18 years of age or older, *Continue to #33*

❒ Less than 18 years of age, *Continue to #32*

32. Is the patient an adult or a pediatric patient between the age of 2 and 17 and the spasticity is not caused by cerebral palsy?

❒ Yes, *Continue to #33*

❒ No, *Continue to #33*

33. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?

❒ Yes, *Continue to #100*

❒ No, *Continue to #100*

40. Is the requested medication prescribed by or in consultation with a neurologist or ophthalmologist?

❒ Yes, *Continue to #41*

❒ No, *Continue to #41*

41. What is the patient's age?

❒ 18 years of age or older, *Continue to #100*

❒ Less than 18 years of age, *Continue to #100*

100. Is this request for continuation of therapy?

❒ Yes, *Continue to #101*

❒ No, *No Further Questions*

101. Was the requested drug effective for treating the diagnosis or condition?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

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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