Dysport

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

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*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

What is the ICD-10 code? _____

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ *Ambulatory Surgical (POS Code 24)*
- ❑ *Home (POS Code 12)*
- ❑ *Off Campus Outpatient Hospital (POS Code 19)*
- ❑ *On Campus Outpatient Hospital (POS Code 22)*
- ❑ *Office (POS Code 11)*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

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D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation***.
❑ Yes ❑ No

Clinical Criteria Questions:

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 3*

❒ Upper limb spasticity, *Continue to 14*

❒ Lower limb spasticity, *Continue to 14*

❒ Blepharospasm, including blepharospasm associated with dystonia and benign essential blepharospasm, *Continue to 17*

❒ Hemifacial spasm, *Continue to 18*

❒ Chronic anal fissures, *Continue to 6*

❒ Excessive salivation (chronic sialorrhea), *Continue to 8*

❒ Primary axillary hyperhidrosis, *Continue to 10*

❒ Other, please specify. _____, *No further questions*

3. 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 4*
❒ No, *Continue to 4*

4. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?
❒ Yes, *Continue to 5*
❒ No, *Continue to 5*

5. What is the patient's age?

❒ 18 years of age or older, *Continue to 19*

❒ Less than 18 years of age, *Continue to 19*

6. Has the patient failed to respond to first-line therapy for chronic anal fissures such as topical calcium channel blockers or topical nitrates?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Is the requested medication prescribed by or in consultation with a gastroenterologist, proctologist, or colorectal surgeon?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

8. Is the patient refractory to pharmacotherapy (e.g., anticholinergics)?
❒ Yes, *Continue to 9*
❒ No, *Continue to 9*

9. Is the requested drug prescribed by or in consultation with a neurologist or otolaryngologist?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

10. Has significant disruption of professional and/or social life occurred because of excessive sweating?
❒ Yes, *Continue to 11*
❒ No, *Continue to 11*

11. Has the patient tried topical aluminum chloride or other extra-strength antiperspirant?
❒ Yes, *Continue to 12*
❒ No, *Continue to 12*

12. Was the topical aluminum chloride or other extra-strength antiperspirant ineffective or result in a severe rash?
❒ Yes, *Continue to 13*
❒ No, *Continue to 13*

13. Is the requested medication prescribed by or in consultation with a neurologist, dermatologist, or internist?

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❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

14. Does the patient have a primary diagnosis of upper or lower limb spasticity or as a symptom of a condition causing limb spasticity (including focal spasticity or equinus gait due to cerebral palsy)?
❒ Yes, *Continue to 15*
❒ No, *Continue to 15*

15. Is the requested medication prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?
❒ Yes, *Continue to 16*
❒ No, *Continue to 16*

16. Is the patient 2 years of age or older?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

17. Is the requested medication prescribed by or in consultation with a neurologist or ophthalmologist?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

18. Will the requested drug be prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?
❒ Yes, *Continue to 19*
❒ No, *Continue to 19*

19. Is this request for continuation of therapy?
❒ Yes, *Continue to 20*
❒ No, *No Further Questions*

20. 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 Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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