Xeomin

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 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? _____

Exception Criteria:

A. Is this a request for the treatment of any of the following: A) Cervical dystonia in an adult, B) Spasticity?
❑Yes, Cervical dystonia in an adult
❑Yes, Spasticity
❑No, none of the above, *skip to Site of Service Questions*

B. *The preferred product for your patient's health plan is Dysport.*
Can the patient's treatment be switched to the preferred product?
❑Yes, *Please obtain Form for preferred product and submit for corresponding PA*
❑No

C. Does the patient have a documented inadequate response or intolerable adverse event to treatment with the preferred product (Dysport)? ***ACTION REQUIRED: If 'Yes', attach supporting chart note(s).***
❑ Yes ❑ No

Send completed form to: Priority Partners Fax: 1-866-212-4756

Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.hopkinshealthplans.org

Site of Service Questions:

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

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

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?

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❒ Cervical dystonia (e.g., torticollis), *Continue to 3*
❒ Blepharospasm, including blepharospasm associated with dystonia or benign essential blepharospasm, *Continue to 13*
❒ Upper limb spasticity, *Continue to 9*
❒ Chronic sialorrhea (excessive salivation), *Continue to 6*
❒ 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 15*
❒ Less than 18 years of age, *Continue to 15*

6. Is the patient refractory to pharmacotherapy (e.g., anticholinergics)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Is the requested medication prescribed by or in consultation with a neurologist or otolaryngologist?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. What is the patient's age?
❒ 2 years of age or older, *Continue to 15*
❒ Less than 2 years of age, *Continue to 15*

9. Is the spasticity the primary diagnosis or as a symptom of a condition causing limb spasticity?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. What is the patient's age?
❒ 18 years of age or older, *Continue to 12*
❒ Less than 18 years of age, *Continue to 11*

11. 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 12*
❒ No, *Continue to 12*

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

13. Is the requested medication prescribed by or in consultation with a neurologist or ophthalmologist?
❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. What is the patient's age?

❒ 18 years of age or older, *Continue to 15*

❒ Less than 18 years of age, *Continue to 15*

15. Is this request for continuation of therapy?
❒ Yes, *Continue to 16*
❒ No, *No Further Questions*

16. 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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