Dysport

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.

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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. Dysport SGM – 03/2021.

Criteria Questions:

1. What is the diagnosis?
   - ❑ Cervical dystonia (e.g., torticollis)
   - ❑ Upper limb spasticity
   - ❑ Lower limb spasticity
   - ❑ Blepharospasm, including blepharospasm associated with dystonia and benign essential blepharospasm
   - ❑ Hemifacial spasm
   - ❑ Chronic anal fissures
   - ❑ Excessive salivation (chronic sialorrhea)
   - ❑ Primary axillary hyperhidrosis
   - ❑ 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 Dysport, was/is there abnormal placement of the head with limited range of motion in the neck? ❑ Yes ❑ No

Section B: Chronic Anal Fissures

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 ❑ No

Section C: Excessive Salivation

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

Section D: Primary Axillary Hyperhidrosis

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

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

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

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

Section E: Upper and Lower Limb Spasticity

12. Is the spasticity the 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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