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Provider Communications, RCR-A3W-04
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December 30, 2025

UPDATED PRIOR AUTHORIZATION CRITERIA FOR BOTULINUMTOXIN PRODUCTS

Dear Provider,

Effective March 1, 2026, the criteria for the botulinumtoxin products in Table 1 will be updated. These products are on the **non-Medicare** list of office-administered drugs requiring prior authorization. **This letter serves as notification of an upcoming change in coverage for this medication under the medical benefit.**

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington, Options, Inc. require prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee's evidence-based criteria for coverage.

Table 1. List of Botulinumtoxin Products that have updated prior authorization criteria:

BRAND NAME	GENERIC NAME	HCPCS
Botox	onabotulinumtoxinA	J0585
Daxxify	daxibotulinumtoxinA-lanm	J0589
Dysport	abobotulinumtoxinA	J0586
Xeomin	incobotulinumtoxinA	J0588
Myobloc	rimabotulinumtoxinB	J0587

Prior Authorization Criteria for Botulinumtoxin Products in Table 1 (changes are in bold):

DRUG NAME	COVERAGE CRITERIA
onabotulinumtoxinA daxibotulinumtoxinA abobotulinumtoxinA incobotulinumtoxinA rimabotulinumtoxinB	Covered for the following indications: 1) Hyperhidrosis. 2) Anal fissures not responding to treatment with topical nitroglycerin ointment. 3) Achalasia in patients who are not candidates for pneumatic dilation. 4) Torticollis (cervical dystonia), other focal dystonia, hemifacial spasms, dysphonia, strabismus, or blepharospasm. 5) Vocal cord granuloma. 6) Cerebral palsy. 7) Limb spasticity due to multiple sclerosis, spinal cord injury, or after stroke with documented functional impairment, hygiene complications, or infection due to spasticity. 8) For the prevention of migraine in adult patients, the following criteria must be met: a) Meet diagnostic criteria for chronic migraine or migraine with muscle tension headache.

DRUG NAME	COVERAGE CRITERIA
	b) Documentation of an adequate trial of 3 formulary preventative agents, 2 of which must be from the following list (minimum of 2 classes required): • tricyclic antidepressants (e.g., nortriptyline, amitriptyline) • beta blockers (e.g., propranolol, metoprolol) • topiramate • divalproex or valproate i) An adequate trial is defined as at least 2 months of a maximally tolerated dose, or documented intolerance or contraindication c) Patient has been seen by a neurology specialist who recommends the trial of botulinum toxin. **d) Note: Botox preferred. Trial, intolerance, or contraindication to Botox is required before approval for Daxxify, Xeomin, or Dysport.** 9) Treatment of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury [SCI], multiple sclerosis [MS]) who have an inadequate response, contraindication, or intolerance to at least two formulary-preferred anticholinergic or antispasmodic medications (i.e., oxybutynin, trospium, solifenacin, mirabegron, etc.). 10) Treatment of urinary incontinence due to idiopathic OAB in adults who have an inadequate response, contraindication, or intolerance to at least two formulary preferred anticholinergic or antispasmodic medications (i.e., oxybutynin, trospium, solifenacin, or mirabegron). 11) Medical necessity review required for sialorrhea in bulbar motor neuron disease and Parkinson's Disease. BotulinumtoxinA (Botox, Xeomin, Dysport, Daxxify) will be approved if the patient meets any of the above criteria **for non-migraine indications.** Myobloc will be approved if clinical failure of Botox, Dysport, Daxxify, or Xeomin occurs in the above circumstances. Botulinum toxin products are not covered for use in combination with other botulinum products for the same treated condition (same diagnosis code). Max Units per Treatment: Overactive Bladder: Botox 200 units, Xeomin 200 units, Dysport 240 units Urinary Incontinence: Botox 100 units, Xeomin 200 units, Dysport 120 units Chronic Migraine: Botox 200 units Max Cumulative Units across all covered indications per treatment period (12 weeks): • Botox: 400 units (adults); 340 units (pediatrics) • Dysport: 1,500 units (adults); 1,000 units (pediatrics) • Xeomin: 400 units (adults and pediatrics) • Myobloc: 5,000 units (adults) • **Daxxify: 1,500 units (adults and pediatrics)**

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/officeinject.

To request prior authorization review, please use the Referral Request online form (login required) located on the Kaiser Permanente provider website. You can also fax your request to the Review Services department toll-free at 1-888-282-2685.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday through Friday, from 8:00 a.m. to 5:00 p.m.

Sincerely,

Ravi Ubriani, MD, Chair
Pharmacy & Therapeutics Committee