

Kaiser Foundation Health Plan of Washington  
 Kaiser Foundation Health Plan of Washington Options, Inc.  
 CONTRACT MANAGER NAME  
 Provider Communications, RCB-C2W-02  
 PO Box 34262, Seattle WA 98124-1262

JULY 19, 2021

**BOTOX PRODUCTS UPDATED PRIOR AUTHORIZATION CRITERIA**

Dear Provider,

**Effective September 1, 2021**, the criteria for the products listed in Table 1 will be updated to include new quantity limits for chronic migraine. These products are on the **non-Medicare** list of office-administered drugs requiring prior authorization. This letter is a notification of the upcoming change in prior authorization criteria required before administering this medication in a physician's office.

**Table 1. List of Botox Products that have Updated Prior Authorization Criteria**

<b>BRAND NAME</b>	<b>GENERIC NAME</b>	<b>HCPCS</b>
<b>Botox</b>	OnabotulinumtoxinA	J0585
<b>Myobloc</b>	RimabotulinumtoxinB	J0587
<b>Dysport</b>	AbobotulinumtoxinA	J0586
<b>Xeomin</b>	IncobotulinumtoxinA	J0588

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington, Options, Inc. requires 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.

**Prior Authorization Criteria for Botox Products (changes are in bold):**

<b>DRUG NAME</b>	<b>COVERAGE CRITERIA</b>
OnabotulinumtoxinA RimabotulinumtoxinB AbobotulinumtoxinA IncobotulinumtoxinA	<ol style="list-style-type: none"> <li>1) Hyperhidrosis.</li> <li>2) Anal fissures not responding to treatment with topical nitroglycerin ointment.</li> <li>3) Achalasia in patients who are not candidates for pneumatic dilation.</li> <li>4) Torticollis (cervical dystonia), other focal dystonia, hemifacial spasms, dysphonia, strabismus, or blepharospasm.</li> <li>5) Vocal cord granuloma.</li> <li>6) Cerebral palsy.</li> <li>7) Limb spasticity due to multiple sclerosis, spinal cord injury or after stroke with documented functional impairment, hygiene complications or infection due to spasticity.</li> <li>8) For prevention of migraine in adult patients, must meet all the following criteria:</li> </ol>

DRUG NAME	COVERAGE CRITERIA
	<p>a) Meet diagnostic criteria for migraine or migraine with muscle tension headache.</p> <p>b) Patients will do what is necessary to eliminate rebound headache prior to authorization for botulinum toxin. Requesting providers will provide attestation that all possible causes of medication overuse headache have been evaluated and eliminated.</p> <p>c) Documentation of an adequate trial of 3 formulary preventative agents, 2 of which must be from the following list (minimum of 2 classes required):</p> <ul style="list-style-type: none"> <li>• tricyclic antidepressants (e.g., nortriptyline, amitriptyline)</li> <li>• beta blockers (e.g., propranolol, metoprolol)</li> <li>• topiramate</li> <li>• divalproex or valproate</li> </ul> <p>i) An adequate trial is defined as at least 2 months of a maximally tolerated dose, or documented intolerance or contraindication</p> <p>d) Patient has been seen by a Neurologist who recommends the trial of botulinum toxin.</p> <p>e) Not covered for concomitant use with CGRP inhibitors used for migraine prophylaxis (e.g., galcanezumab-gnlm, erenumab-aooe, fremanezumab-vfrm, eptinezumab-jjmr)</p> <p>9) Treatment of urinary incontinence due to detrusor over activity associated with a neurologic condition (e.g., spinal cord injury (SCI), multiple sclerosis (MS)) who have an inadequate response to or are intolerant of at least 2 formulary-preferred anticholinergic medications (i.e. oxybutynin, trospium, solifenacin, etc.).</p> <p>10) Treatment of urinary incontinence due to idiopathic OAB in adults who have an inadequate response, contraindication or intolerance to at least 2 formulary anticholinergic chemical entities (i.e. oxybutynin, trospium, or solifenacin.).</p> <p>11) Medical necessity review required for sialorrhea in bulbar motor neuron disease and Parkinson's Disease.</p> <p>BotulinumtoxinA (Botox, Xeomin, Dysport) will be approved if the patient meets any of the above criteria. Myobloc will be approved if clinical failure of Botox, Dysport, or Xeomin in above circumstances.</p> <p>Max Units per Treatment:</p> <p>Overactive Bladder: Botox 200 units, Xeomin 200 units, Dysport 240 units  Urinary Incontinence: Botox 100 units, Xeomin 200 units, Dysport 120 units</p> <p><b>Chronic Migraine: Botox 200 units</b></p> <p><u>Note:</u> Myobloc will only be approved if clinical failure of Botox, Dysport, or Xeomin in above circumstances.</p>

### **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/> under the “Authorization & Clinical Review” section. Using the website search feature, search for the term “Non-Medicare Injectable Drugs Requiring Prior Authorization.”

To request prior authorization review, please use the Referral Request online form located on the Kaiser Permanente provider website listed above. 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 – Friday from 8 a.m. to 5 p.m.

Sincerely,

A handwritten signature in black ink that reads "Peter Barkett MD". The signature is cursive and includes the letters "MD" at the end.

Peter Barkett, MD, Chair  
Pharmacy & Therapeutics Committee