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BOTOX PRODUCTS UPDATED PRIOR AUTHORIZATION CRITERIA

Dear Provider,

Effective March 1, 2022, the criteria for the products listed in Table 1 will be updated to include new cumulative quantity limits. 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

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

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington, Options, Inc. (Kaiser Permanente) 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):

DRUG NAME	COVERAGE CRITERIA
OnabotulinumtoxinA RimabotulinumtoxinB AbobotulinumtoxinA IncobotulinumtoxinA	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 prevention of migraine in adult patients, must meet all the following criteria: a) Meet diagnostic criteria for migraine or migraine with muscle tension headache.

DRUG NAME	COVERAGE CRITERIA
	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. 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): • 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 d) Patient has been seen by a Neurologist who recommends the trial of botulinum toxin. e) Not covered for concomitant use with CGRP inhibitors used for migraine prophylaxis (e.g., galcanezumab-gnlm, erenumab-aooe, fremanezumab-vfrm, eptinezumab-jjmr) 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.). 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.). 11) Medical necessity review required for sialorrhea in bulbar motor neuron disease and Parkinson's Disease. 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. Botulinum toxin products 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)**

DRUG NAME	COVERAGE CRITERIA
	ICD-10 code needed to auto-auth with specific code *(corresponds with numbered criteria above)* *1) R61, L74.510, L74.511, L74.512, L74.513, L74.519, L74.52* *4) G24.1, G24.3, G24.4, G24.5, G24.8, G24.9, G25.89, G51.2, G51.4, G51.8, H50.00-H51.9, M43.6, R49.8* *5) J38.3* *6) G80.0, G80.1, G80.2, G80.3, G80.8, G80.9* Note: Myobloc will only be approved if clinical failure of Botox, Dysport, or Xeomin in above circumstances.

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. 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 through Friday from 8 a.m. to 5 p.m.

Sincerely,

Peter Barkett, MD, Chair
Pharmacy & Therapeutics Committee