Field Name	Field Description
Prior Authorization Group Description	**Botulinum Toxins A&B**
Drugs	**Preferred Agents for FDA approved indications:** IncobotulinumtoxinA (Xeomin) AbobotulinumtoxinA (Dysport) **Non-preferred Agents:** OnabotulinumtoxinA (Botox) RimabotulinumtoxinB (Myobloc) DaxibotulinumtoxinA (Daxxify) Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	According to package insert
Prescriber Restrictions	None
Coverage Duration	If all of the conditions are met, the request will be approved for 12 month duration.
Other Criteria	****The use of these medications for cosmetic purposes is NOT a covered benefit under the Medical Assistance program**** **For Initial Approval:** • The drug is being used for a medically accepted indication and dose as outlined in Covered Uses • The member has tried and failed standard first line therapy for their disease state and/or has a documented medical reason (intolerance, hypersensitivity, contraindication, etc.) for not using first line therapy • If the diagnosis is **Chronic Migraines** (≥15 days per month with headache lasting 4 hours a day or longer), the member has tried and failed, or has a medical reason for not using one drug from two of the following categories for at least 4 weeks each at a minimum effective dose: o Beta blockers (e.g. propranolol, timolol, etc.) o Amitriptyline or venlafaxine o Topiramate, divalproex ER or DR, or valproic acid

Revision/Review Date 11/2024	• If the diagnosis is **Overactive Bladder**, the member has tried and failed 2 formulary drugs (e.g. oxybutynin)
	• If the diagnosis is **Hyperhidrosis,** the member has tried and failed a prescription strength antiperspirant (e.g. 20% aluminum chloride hexahydrate)
	• If the diagnosis is **Chronic Sialorrhea,**
	  o Documentation is provided that the member has had sialorrhea lasting at least 3 months
	  o The member has tried and failed, or has a medical reason for not using, an anticholinergic medication (e.g. glycopyrrolate, hyoscyamine, benztropine)
	• If the request is for a non-preferred agent, the member tried and failed a preferred agent if appropriate for the requested indication
	
	For Reauthorization:
	• Documentation of provider attestation that demonstrates a clinical benefit
	• The requested drug is for a medically accepted dose as outlined in Covered Uses
	
	Physician/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.