DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID
DRUG USE REVIEW (DUR) BOARD
PROPOSED PRIOR AUTHORIZATION CRITERIA

Botulinum toxins are a covered benefit of Nevada Medicaid for recipients who meet the criteria for coverage.

1. Coverage and Limitations:
Authorization will be given if the following criteria are met and documented:

Requests for Dysport® (abobotulinumtoxinA)
1. Must have the following:
    a. The recipient has a diagnosis cervical dystonia.

Requests for Xeomin® (incobotulinumtoxinA)
1. Must have ONE of the following:
    a. The recipient has a diagnosis cervical dystonia.

    b. The recipient has a diagnosis of blepharospasm and was previously treated with Botox®.

Requests for Botox® (onabotulinumtoxinA)
1. Must have ONE of the following:
    a. The requested medication will be used for the prophylaxis of chronic migraines.
    AND
    The recipient has ≥15 days per month with headaches that last four hours a day or longer.
    AND
    The recipient has experienced an inadequate response or adverse event with at least one beta blocker, or has a contraindication to treatment with these agents.
    AND
    The recipient has experienced an inadequate response or adverse event with at least one of the following: amitriptyline, topiramate, valproic acid, venlafaxine, or has a contraindication to treatment with these agents.

    c. The recipient has a diagnosis of cervical dystonia.

    d. The recipient has a diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency and frequency.
    AND
    The recipient has experienced an inadequate response or adverse event with at least two anticholinergic medications, or has a contraindication to treatment with these agents.

    e. The recipient has a diagnosis of severe primary axillary hyperhidrosis.
    AND

The recipient has experienced an inadequate response or adverse event with aluminum chloride topical solution, or has a contraindication to treatment with this agent.

f. The recipient has a diagnosis of strabismus or blepharospasm associated with dystonia (including benign essential blepharospasm or VII nerve disorders).

g. The recipient has a diagnosis of upper limb spasticity.

h. The recipient has a diagnosis of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis).
AND
The recipient has experienced an inadequate response or adverse event with at least two anticholinergic medications, or has a contraindication to treatment with these agents.

Requests for Myobloc® (rimabotulinumtoxinB)

1. Must have the following:
   a. The recipient has a diagnosis cervical dystonia.

2. PA Guidelines:
Prior Authorization approval will be 3 months for initial requests.
Prior Authorization approval will be 1 year for requests for continuing treatment.

3. Quantity Limitations:
N/A