

BOTULINUM TOXINS PRIOR AUTHORIZATION FORM

(form effective 1/3/2022)



Fax to PerformRxSM at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	Total # pages:	Name of office contact:
Contact's phone number:	LTC facility contact/phone:	

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
State license #:	NPI:	MA Provider ID #:
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

CLINICAL INFORMATION

Product requested: <input type="checkbox"/> Botox (preferred with clinical PA required) <input type="checkbox"/> Dysport (preferred with clinical PA required) <input type="checkbox"/> Myobloc (non-preferred) <input type="checkbox"/> Xeomin (non-preferred)		
Strength:	Injection site(s) and dose per site:	Qty requested:
Diagnosis (submit documentation):	DX code (required):	

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
<input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

INITIAL REQUESTS (Complete questions applicable to drug requested and patient's diagnosis):

- Request for a non-preferred agent (Myobloc or Xeomin):** Does the patient have a history of trial and failure, contraindication, or intolerance of the preferred Botulinum Toxins that are FDA-approved for the patient's diagnosis and age? Check all that apply. Botox Dysport
 Yes No N/A *Submit documentation of all medications tried and outcomes.*
- Axillary hyperhidrosis:** Does the patient have a history of trial and failure, contraindication, or intolerance of a topical agent such as 20% aluminum chloride?
 Yes No *List medications tried.*
- Overactive bladder:** Does the patient have a history of trial and failure, contraindication, or intolerance of at least two other medications used to treat OAB?
 Yes *List medication tried:*
 No
- Urinary incontinence due to detrusor overactivity associated with a neurologic condition:** Does the patient have a history of trial and failure, contraindication, or intolerance of at least one anticholinergic medication used to treat urinary incontinence? Yes No *List medications tried.*
- Migraine, Chronic:** Check all of the following that apply to the patient and submit documentation for each.
 Has a diagnosis of chronic migraine headache according to the current International Headache Society Classification of Headache Disorders that is not attributed to other causes including medication overuse
 History of trial and failure, contraindication, or intolerance of triptans and/or ergotamine medications to relieve migraine symptoms
 The requested agent is prescribed by, or in consultation with, one of the following specialists. Submit documentation of consultation, if applicable.
 neurologist headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)
 History of trial and failure, contraindication, or intolerance of an agent in at least two of the following drug classes used for migraine prevention:
 anticonvulsants beta blockers antidepressants
List medications tried:
- Spasticity, Chronic:** Check all of the following that apply to the patient and submit documentation for each.
 has spasticity that: interferes with activities of daily living is expected to result in joint contracture with future growth
 if the patient has developed contractures, has been considered for surgical intervention
 if ≥ 18 years of age, has tried and failed, or has a contraindication or intolerance of, an oral medication for spasticity
 drug is being requested to either: enhance function --OR-- allow for additional therapeutic modalities to be employed
 drug will be used in conjunction with other appropriate therapeutic modalities (e.g., OT, PT, gradual splinting)
List medications tried:
- All other diagnoses:** Submit documentation supporting the use of the requested agent for the patient's diagnosis and other treatments tried:

RENEWAL REQUESTS

Check all that apply: <input type="checkbox"/> Patient showed tolerability and a positive clinical response to the medication <input type="checkbox"/> Patient's symptoms returned to such a degree that repeat injection is required

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:
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