# BOTULINUM TOXINS
# PRIOR AUTHORIZATION FORM

(form effective 1/5/21)

AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

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

## PRIOR AUTHORIZATION REQUEST INFORMATION

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|---|---|---|
| ☐ New request ☐ Renewal request | Total # pages: | Name of office contact: |
| Contact's phone number: | | LTC facility contact/phone: |

## PATIENT INFORMATION

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

## PRESCRIBER INFORMATION

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

## CLINICAL INFORMATION

Product requested: ☐ Botox (preferred with clinical PA required) ☐ Dysport (preferred with clinical PA required) ☐ Myobloc (non-preferred) ☐ Xeomin (non-preferred)

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| Strength: | Injection site(s) and dose per site: | Qty requested: |
| Diagnosis (submit documentation): | | DX code (required): |

For females of childbearing age, is the patient pregnant or breastfeeding? ☐ Yes ☐ No ☐ N/A

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

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

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| Pharmacy Phone #: | Pharmacy Fax #: |

☐ 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):

1. **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.*

2. **Axillary hyperhydrosis:** Does the patient have a history of trial and failure, contraindication, or intolerance of prescription-strength aluminum chloride antiperspirant?
   ☐ Yes ☐ No *Submit documentation.*

3. **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 *Submit documentation of all medications tried and outcomes.*

4. **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 two other medications used to treat urinary incontinence? ☐ Yes ☐ No *Submit documentation of all medications tried and outcomes.*

5. **Migraine, Chronic:** Check all of the following that apply to the patient and submit documentation for each.
   - ☐ Diagnosed with chronic migraine not attributed to other causes, as defined by:
     - ☐ Headache on greater than or equal to 15 days per month for at least 3 months
     - ☐ At least five attacks include at least two of the following (check all that apply)
       - ☐ unilateral location ☐ pulsating quality ☐ moderate or severe intensity
       - ☐ aggravation by or causing avoidance of routine physical activity
     - ☐ During headache, the following occur:
       - ☐ Nausea and/or vomiting ☐ Photophobia and phonophobia
   - ☐ History of trial and failure, contraindication, or intolerance of triptans and/or ergotamine medications to relieve migraine symptoms
   - ☐ History of trial and failure, contraindication, or intolerance of an agent in at least 3 of the following drug classes used for migraine prevention:
     - ☐ anticonvulsants ☐ beta blockers ☐ calcium channel blockers
     - ☐ tricyclic antidepressants

   List medications tried:

6. **Spasticity, Chronic:** Check all of the following that apply to the patient and submit documentation for each.
   - ☐ has spasticity caused by: ☐ cerebral palsy ☐ multiple sclerosis ☐ spinal cord injury ☐ stroke ☐ traumatic brain injury
   - ☐ has spasticity that: ☐ interferes with activities of daily living is expected to result in joint contracture
   - ☐ 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:

7. **Strabismus:** Check all of the following that apply to the patient and submit documentation for each.
   - ☐ does NOT have Duane's syndrome, restrictive strabismus, or strabismus caused by surgery
   - ☐ current deviation measures LESS than 50 prism diopters
   - ☐ drug has potential to restore binocular vision

8. **All other diagnoses:** Submit documentation supporting the use of the requested agent for the patient's diagnosis and other treatments tried:

## RENEWAL REQUESTS

1. *Submit justification and documentation supporting the need for repeat injection.*

## PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

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| Prescriber signature: | Date: |