

BOTULINUM TOXINS PRIOR AUTHORIZATION FORM



Keystone First

PERFORMRxSM
Next Generation Pharmacy Benefits

(form effective 1/1/20)

Fax to PerformRxSM at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

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):	
For females of childbearing age, is the patient pregnant or breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		

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 prescription-strength aluminum chloride antiperspirant?
 Yes No *Submit documentation.*
- 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.*
- 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.*
- Migraine, Chronic:** Check all of the following that apply to the patient and submit documentation for each.
 diagnosed with chronic migraine as per the International Headache Society's Classification of Migraines
 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 NSAIDs tricyclic antidepressants
List medications tried:
- 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:
- 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
- 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

Prescriber signature:	Date:
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