pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

BOTULINUM TOXINS PRIOR AUTHORIZATION FORM

Botulinum Toxins and **Quantity Limits/Daily Dose Limits** prior authorization guidelines: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested:	☐Botox (preferred with clinical PA required) ☐*Myoboc (non-preferred)* ☐Dysport (preferred with clinical PA required) ☐Xeomin (preferred with clinical PA required)	
Strength:	Injection site(s) & dose per site:	Qty requested:
Diagnosis (*submit documentation*):		Dx code (*required*):
Specialty Pharmacy Drug Program: Which specialty pharmacy will be used?	☐Diplomat Specialty	☐Walgreen's Specialty

INITIAL requests – complete questions applicable to drug requested and beneficiary's diagnosis

1. ***Request for a non-preferred agent (Myobloc)***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Botulinum Toxins that are FDA-approved for the beneficiary's diagnosis and age? *Check all that apply.* ☐Botox ☐Dysport ☐Xeomin	☐Yes ☐No ☐N/A	*Submit documentation of all medications tried and outcomes.*
2. ***Axillary hyperhydrosis***: Does the beneficiary 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 beneficiary have a history of trial and failure, contraindication, or intolerance of at least two other medications used to treat OAB?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
4. ***Urinary incontinence due to detrusor overactivity associated with a neurologic condition:*** Does the beneficiary 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 beneficiary and *submit documentation for each*.
   - ☐diagnosed with chronic migraine as per the International Headache Society's Classification of Migraines
   - ☐history of trial & failure, contraindication, or intolerance of triptans and/or ergotamine medications to relieve migraine symptoms
   - ☐history of trial & 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
6. ***Spasticity, Chronic***: Check all of the following that apply to the beneficiary 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 beneficiary has developed contractures, has been considered for surgical intervention
   - ☐if ≥ 18 years of age, has tried & 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 (eg, OT, PT, gradual splinting)
7. ***Strabismus***: Check all of the following that apply to the beneficiary 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
8. ***All other diagnoses:*** Submit documentation supporting the use of the requested agent for the beneficiary's diagnosis & other treatments tried.

RENEWAL requests

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

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: