

BOTULINUM TOXINS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Botulinum Toxins** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pages _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Units/pkg size:
Injection site(s) & dose per site:	Qty requested:
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):
Dates of previous administration and injection sites (<i>submit documentation</i>):	

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

Request for a non-preferred agent: 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? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Submit documentation of all medications tried and outcomes.
Axillary hyperhidrosis: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of prescription-strength aluminum chloride antiperspirant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Submit documentation.
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Submit documentation of all medications tried and outcomes.
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Submit documentation of all medications tried and outcomes.
Migraine, chronic: Check all of the following that apply to the beneficiary and <i>submit documentation for each</i> . <input type="checkbox"/> diagnosed with chronic migraine as per the International Headache Society's Classification of Migraines <input type="checkbox"/> history of trial & failure, contraindication, or intolerance of triptans and/or ergotamine medications to relieve migraine symptoms <input type="checkbox"/> history of trial & failure, contraindication, or intolerance of an agent in at least 3 of the following drug classes used for migraine prevention: <input type="checkbox"/> anticonvulsants <input type="checkbox"/> beta blockers <input type="checkbox"/> calcium channel blockers <input type="checkbox"/> NSAIDs <input type="checkbox"/> tricyclic antidepressants		
Spasticity, chronic: Check all of the following that apply to the beneficiary and <i>submit documentation for each</i> . <input type="checkbox"/> has spasticity caused by: <input type="checkbox"/> cerebral palsy <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> spinal cord injury <input type="checkbox"/> stroke <input type="checkbox"/> traumatic brain injury <input type="checkbox"/> has spasticity that: <input type="checkbox"/> interferes with activities of daily living <input type="checkbox"/> is expected to result in joint contracture <input type="checkbox"/> if the beneficiary has developed contractures, has been considered for surgical intervention <input type="checkbox"/> if ≥ 18 years of age, has tried & failed, or has a contraindication or intolerance of, an oral medication for spasticity <input type="checkbox"/> drug is being requested to either: <input type="checkbox"/> enhance function --OR-- <input type="checkbox"/> allow for additional therapeutic modalities to be employed <input type="checkbox"/> drug will be used in conjunction with other appropriate therapeutic modalities (eg, OT, PT, gradual splinting)		
Strabismus: Check all of the following that apply to the beneficiary and <i>submit documentation for each</i> . <input type="checkbox"/> does NOT have Duane's syndrome, restrictive strabismus, or strabismus caused by surgery <input type="checkbox"/> current deviation measures LESS than 50 prism diopters		

All other diagnoses: Submit documentation supporting the use of the requested agent for the beneficiary's diagnosis & other treatments tried.

RENEWAL requests

Submit documentation supporting the need for repeat injection and dates/injections sites of previous administration.

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

Prescriber Signature:	Date:
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