PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Botox® (Botulinum Toxin Type A)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip:	City, State, Zip:	
Member Phone:		

Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:
Q1. What is the requested duration of therapy? 3 months or less More than 3 months
Q2. Is the prescribing physician a: Neurologist Urologist Physiatrist Ophthalmologist Other (please define):
Q3. Is the dose: Less than or equal to 200 units per treatment and occurring no sooner than 3 months apart Cumulative and less than or equal to 200 units and occurring no sooner than 3 months Less than or equal to 155 units per treatment and occurring no sooner than 3 months apart Less than or equal to 100 units and occurring no sooner than 3 months Less than or equal to 50 units per site and occurring no sooner than 3 months Less than or equal to 50 units per axilla and occurring no sooner than 3 months
Q4. Has the prescriber submitted documentation of the proposed injection site(s) and the dose injected into each site? Yes No
Q5. Is the member greater than or equal to 18 years of age with a documented diagnosis of overactive bladder (OAB) with symptoms of urge urinary incontinence? Yes No
Q6. If the member has an active urinary tract infection (UTI), is the member being treated with antibiotics before considering treatment with Botox®? Yes No

Health Partners Plans

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Q7. Is the member greater than or equal to 18 years of age with a documented diagnosis of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis)?

Yes No

Q8. Due to the risk of urinary retention, is the member willing and able to initiate catheterization post-treatment, if required?

Yes No

Q9. Has the member had an inadequate response to OR failure of two anticholinergic medication(s) indicated for the treatment of urinary incontinence (e.g., oxybutynin / oxybutynin ER, Detrol / Detrol LA, Enablex, Toviaz, Vesicare)?

Yes No

Q10. Is the member greater than or equal to 18 years of age with a documented diagnosis of migraine headaches occuring greater than or equal to 15 days per month with headache lasting 4 hours a day or longer?

Yes No

Q11. Has the member had an inadequate response to or failure of two first-line prophylactic medications (e.g., beta blockers such as propanolol, metoprolol; amitriptyline; topiramate; valproic acid; and its derivatives)?

Yes No

Q12. Is the member greater than or equal to 18 years of age with a documented diagnosis of upper limb spasticity where Botox is being used to decrease the severity of increased muscle tone in elbow flexors (bicepts), wrist flexors (flexor carpi radialis and flexor carpi ulnaris) and/or finger flexors (flexor digitorum profundus and flexor digitorum sublimis)?

Yes No

Q13. Has the member had a documented failure to control spasticity by conventional therapies (e.g., physical therapy, splinting, bracing, and two systemic antispasticity medications such as cyclobenzaprine, tizanidine, baclofen?

Yes No

Q14. Is the member greater than or equal to 16 years of age with a documented diagnosis of cervical dystonia where Botox is being used to reduce the severity of abnormal head position and neck pain?

Yes No

Q15. Is the member greater than or equal to 18 years of age with documented diagnosis of persistent primary axillary hyperhidrosis with a score of 3 or 4 on a Hyperhidrosis Disease Severity Scale (HDSS)*?

Yes No

Q16. Has the member had an inadequate response to or failure of topical aluminum chloride 20% solution?

Yes No

Q17. Is the member greater than or equal to 12 years of age with a documented diagnosis of blepharospasm associated with dystonia?

Yes No

Q18. Is the member greater than or equal to 12 years of age with a documented diagnosis of strabismus?

Yes No

Q19. Comments:

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Q20. Deliver to:

Physician's Office Home Delivery

Q21. Delivery date needed:

Physician Signature **Date**

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