HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Botulinum Toxins - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: ☐ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a renewal request?
If No, go to 3.

☐ Yes ☐ No

Q2. Has the prescriber provided medical documentation to support the need for repeat treatment(s) occurring no sooner than every 3 months?
If Yes, go to 14.

☐ Yes ☐ No

Q3. Is the patient greater than or equal to 18 years of age with a documented diagnosis of overactive bladder (OAB) with symptoms of urge urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis)?
If No, go to 5.

☐ Yes ☐ No

Q4. Has the patient had an inadequate response or intolerance to at least one anticholinergic medication (e.g., oxybutynin/oxybutynin ER, tolterodine/ tolterodine ER, trospium/ trospium ER)?
If Yes, go to 14.

☐ Yes ☐ No

Q5. Is the patient greater than or equal to 18 years of age with a documented diagnosis of migraine headaches occurring greater than or equal to 15 days per month with headaches lasting 4 hours per day or longer?
If No, go to 7.

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Has the patient had an inadequate response or intolerance to at least 2 different classes of prophylactic medications (i.e., beta blockers [such as propranolol, metoprolol], amitriptyline, topiramate, valproic acid or its derivatives, verapamil)?
If Yes, go to 14.

☐ Yes ☐ No

Q7. Does the patient have a documented diagnosis of sialorrhea associated with disorders of the nervous system or neurologic dysfunction?
If No, go to 9.

☐ Yes ☐ No

Q8. Has the patient had an inadequate response or intolerance to at least 1 anticholinergic medication (e.g., glycopyrrolate)?
If Yes, go to 15.

☐ Yes ☐ No

Q9. Is the patient greater than or equal to 18 years of age with a documented diagnosis of severe primary axillary hyperhidrosis?
If Yes, go to 14.

☐ Yes ☐ No

Q10. Is the patient 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 (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris), finger flexors (flexor digitorum profundus and flexor digitorum sublimis), or thumb flexors (adductor pollicis and flexor pollicis longus)] or lower limb spasticity where Botox® is being used to decrease the severity of increased muscle tone [in ankle or toe flexors (gastrocnemius, soleus, tibialis posterior, flexor hallucis longus, and flexor digitorum longus)]?
If Yes, go to 14.

☐ Yes ☐ No

Q11. Is the patient greater than or equal to 16 years of age with a reduced diagnosis of cervical dystonia where Botox is being used to reduce the severity of abnormal head position and neck pain?
If Yes, go to 14.

☐ Yes ☐ No

Q12. Is the patient greater than or equal to 12 years of age with a documented diagnosis of blepharospasm or strabismus associated with dystonia?

☐ Yes ☐ No

Q13. Does the patient have a documented diagnosis of spasticity associated with cerebral palsy, hemifacial spasm, or laryngeal dystonia?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q14. Is the prescribing physician a specialist in the condition (e.g., urologist for overactive bladder or urinary incontinence; neurologist for migraine headaches; neurologist or physiatrist for upper limb spasticity, cervical dystonia, or hyperhidrosis; ophthalmologist for blepharospasm or strabismus)?

☐ Yes ☐ No

Q15. Has the prescriber submitted documentation of the proposed injection site(s) and the dose that will be injected into each site?

☐ Yes ☐ No

Q16. Is the dose in accordance with the recommended dosing below and occurring no sooner than every 3 months?
- Overactive bladder- up to 100 units per treatment
- Urinary incontinence- up to 200 units per treatment
- Chronic migraine- up to 155 units per treatment
- Upper limb spasticity- up to 400 units per treatment
- Cervical dystonia- up to 300 units per treatment (up to 50 units per site)
- Hyperhidrosis- up to 100 units per treatment (up to 50 units per axila)
- Blepharospasm- up to 200 units per treatment
- Strabismus- up to 25 units per muscle per injection

☐ Yes ☐ No

Q17. Additional Information:

Q18. Requested Duration:

☐ 12 Months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request

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