

Pharmacy Prior Authorization Form

Last Reviewed: March 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Botox[®] (botulinum toxin-type A) and Myobloc[®] (botulinum toxin-type B)

Urgent Non-urgent

Note: PA not required for Neurologists and Psychiatrists

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

- Botox 100 unit vial
 Myobloc 3.5 ml vial

Dose: _____ Start date: _____

Place of administration:

- Self-administered
 Provider's Office
 Outpatient Infusion Center Name of center: _____
 Home Infusion Name of agency: _____

Billing options:

- Physician buy and bill (Botox-J0585; Myobloc-J0587)
 Preferred Specialty Vendor
 Other: _____

Prescriber a neurologist or psychiatrist:

- Yes
 No

Priority Health Precertification Requirements:

Authorization of botulinum toxin requires one of the following diagnoses:

Diagnosis:

1. Anal fissures– ICD code: _____ **(NOT COVERED FOR MEDICARE)**

Patient has had a documented therapeutic trial of nitroglycerine ointment (**required**):

- Yes
 No - rationale for use: _____

2. Esophageal achalasia– ICD code: _____
3. Blepharospasm– ICD code: _____
4. Focal axillary hyperhidrosis– ICD code: _____
5. Cerebral palsy– ICD code: _____
6. Cervical dystonia– ICD code: _____
7. Demyelinating diseases of the CNS and copus callosum including Leukodystrophy– ICD code: _____
8. Facial nerve VII disorders (facial myokymia, Melkersson’s syndrome, facial/hemifacial spasms) – ICD code: _____
9. Focal hand dystonia (i.e., organic writer’s cramp) – ICD code: _____
10. Hereditary spastic paraplegia– ICD code: _____
11. Lingual dystonia– ICD code: _____
12. Multiple sclerosis– ICD code: _____
13. Neuromyelitis optica– ICD code: _____
14. Orofacial dyskinesia– ICD code: _____
15. Schilder’s disease– ICD code: _____
16. Spastic hemiplegia due to stroke or brain injury– ICD code: _____
17. Strabismus– ICD code: _____
18. Torsion dystonia, idiopathic and symptomatic– ICD code: _____
19. Torticollis– ICD code: _____
20. Jaw-closing oromandibular dystonia– ICD code: _____
21. Laryngeal spasm, laryngeal adductor spastic dysphonia or stradulus– ICD code: _____

22. Ptyalism/sialorrhea (excessive secretion of saliva, drooling) that is refractory to pharmacotherapy– ICD code: _____
 Patient has had a documented therapeutic trial of anticholinergic therapy (**required**):
 Yes
 No - rationale for use: _____

23. Headache (cervicogenic, cluster, migraine, or tension– ICD code: _____
(NOT COVERED FOR MEDICARE)
 Headaches are disabling (**required**):
 Yes
 No - rationale for use: _____
 Patient has had a documented therapeutic trial of **three** of the following classes (**required**):
 Reason for failure

<input type="checkbox"/> NSAIDs:	<input type="checkbox"/> Did not work	<input type="checkbox"/> Side effects	<input type="checkbox"/> Contraindication_____
<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Did not work	<input type="checkbox"/> Side effects	<input type="checkbox"/> Contraindication_____
<input type="checkbox"/> Triptans	<input type="checkbox"/> Did not work	<input type="checkbox"/> Side effects	<input type="checkbox"/> Contraindication_____
<input type="checkbox"/> Ergotamines	<input type="checkbox"/> Did not work	<input type="checkbox"/> Side effects	<input type="checkbox"/> Contraindication_____
<input type="checkbox"/> Opioid Analgesics	<input type="checkbox"/> Did not work	<input type="checkbox"/> Side effects	<input type="checkbox"/> Contraindication_____

 If no, rationale for use: _____

Patient has consistent jaw, head, or neck muscle spasm:

Yes

No

24. Other: _____ – ICD code: _____ Please provide rationale for use:

Duration of therapy:

- If approved, authorization will be for one dose every 90 days for one year. It is usually considered not medically necessary to give botulinum toxin injection more frequently than every 90 days.

Note: Priority Health Medicare applies CMS local coverage determination criteria when available for Part B drugs. If no local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX