

# Pharmacy

## PRIOR AUTHORIZATION FORM

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

# Botulinum Toxin

**URGENT** (life threatening)

**Non-Urgent** (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

### Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

### Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

Is this provider a neurologist or psychiatrist?  Yes  No

### PRODUCT INFORMATION

#### Botulinum toxin – Type A

- Botox<sup>®</sup> 100 unit vial  
 Botox<sup>®</sup> 200 unit vial  
 Dysport<sup>®</sup> 300 unit vial  
 Dysport<sup>®</sup> 500 unit vial  
 Xeomin<sup>®</sup> 50 unit vial  
 Xeomin<sup>®</sup> 100 unit vial

#### Botulinum toxin – Type B

- Myobloc<sup>®</sup> 2,500 unit vial  
 Myobloc<sup>®</sup> 5,000 unit vial  
 Myobloc<sup>®</sup> 10,000 unit vial

Dose: \_\_\_\_\_

Start Date: \_\_\_\_\_

### BILLING INFORMATION

#### Place of administration:

- Provider's Office  
 Other: \_\_\_\_\_

#### Billing Options:

- Physician buy and bill  
 Preferred Specialty Vendor  
 Other: \_\_\_\_\_

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**PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION IS REQUIRED FOR REIMBURSEMENT**  
**Authorization for *botulinum toxin* requires the following information to certify:**

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**Patient must have one of the following diagnoses** (step therapy and additional requirements listed below individual indication):

1.  Anal fissures ICD code \_\_\_\_\_
  - a. *Patient had a documented therapeutic trial of nitroglycerin ointment (required)?*  
 Yes  No – Rationale for use: \_\_\_\_\_
  
2.  Blepharospasm ICD code \_\_\_\_\_
3.  Cerebral palsy ICD code \_\_\_\_\_
4.  Cervical dystonia ICD code \_\_\_\_\_
5.  Demyelinating diseases of the CNS and  
 corpus callosum including Leukodystrophy ICD code \_\_\_\_\_
6.  Detrusor Overactivity associated with a Neurologic Condition ICD code \_\_\_\_\_
  - a. *Patient's urinary incontinence is due to detrusor overactivity associated with a neurological condition (e.g. spinal cord injury, multiple sclerosis)?*  
 Yes - Neurological condition: \_\_\_\_\_  
 No – Rationale for use: \_\_\_\_\_
  - b. *Patient had a therapeutic trial and clinical failure with, or is intolerant to, an anticholinergic medication?*  
 Yes - Medication used: \_\_\_\_\_  
 No – Rationale for use: \_\_\_\_\_
  
7.  Esophageal achalasia ICD code \_\_\_\_\_
8.  Facial nerve VII disorder ICD code \_\_\_\_\_  
*(facial myokymia, Melkersson's syndrome, facial/hemifacial spasms)*
9.  Focal axillary hyperhidrosis ICD code \_\_\_\_\_
10.  Focal hand dystonia (i.e. organic writer's cramp) ICD code \_\_\_\_\_
11.  Gastroparesis ICD code \_\_\_\_\_

Note: coverage for gastroparesis is available only as an alternative for patients who would otherwise require daily total parenteral nutrition (TPN) in the home. Botulinum toxin and TPN will not be authorized together for treatment of gastroparesis. Patients using botulinum toxin must meet the same criteria for TPN. **To determine if patient meets criteria for botulinum toxin, submit the TPN medical prior authorization form with this request.** The form is available online at: <http://www.priorityhealth.com/provider/forms/~media/documents/provider-authorizations/tpn-pa-form.ashx>.

12.  **Migraine** headache ICD code \_\_\_\_\_  
 Note: cluster, tension, and cervicogenic headaches are *not* a covered benefit.

a. *Are the patient's headaches disabling?*

Yes

No – Rationale for use: \_\_\_\_\_

b. *Patient had a documented therapeutic trial with **three** of the following classes that did not work, patient experienced side effects, or has a contraindication to (required):*

Acetaminophen Outcome: \_\_\_\_\_

Ergotamine Outcome: \_\_\_\_\_

NSAIDs Outcome: \_\_\_\_\_

Triptans Outcome: \_\_\_\_\_

Opioid Analgesics Outcome: \_\_\_\_\_

c. **Note:** Use of botulinum toxin is covered by only for the prophylaxis of headaches in adult patients with chronic migraine ( $\geq 15$  days per month with headache lasting 4 hours a day or longer). Does the patient meet this criteria?  Yes  No

13.  Hereditary spastic paraplegia ICD code \_\_\_\_\_

14.  Hyperhidrosis (primary axillary) ICD code \_\_\_\_\_

a. *Patient had a documented therapeutic trial of topical aluminum chloride or other extra-strength antiperspirants or these therapies result in a severe rash (required)?*

Yes  No – Rationale for use: \_\_\_\_\_

b. *Patient had a documented trial of systemic pharmacotherapy prescribed for excessive sweating (e.g. anticholinergics, beta-blockers, or benzodiazapines) (required)?*

Yes  No – Rationale for use: \_\_\_\_\_

15.  Jaw-closing oromandibular dystonia ICD code \_\_\_\_\_

16.  Laryngeal spasm  
 Laryngeal adductor spastic dysphonia or stradulus ICD code \_\_\_\_\_

17.  Lingual dystonia ICD code \_\_\_\_\_

18.  Multiple Sclerosis ICD code \_\_\_\_\_

19.  Neuromyelitis optica ICD code \_\_\_\_\_

20.  Orofacial dyskinesia ICD code \_\_\_\_\_

21.  Ptyalism/sialorrhoea refractory to pharmacotherapy ICD code \_\_\_\_\_

a. *Patient had a documented therapeutic trial of anticholinergic therapy (required)?*

Yes  No – Rationale for use: \_\_\_\_\_

22.  Schilder's disease ICD code \_\_\_\_\_

23.  Spastic hemiplegia due to storke or brain injury ICD code \_\_\_\_\_

24.  Strabismus ICD code \_\_\_\_\_
25.  Torsion dystonia, idiopathic and symptomatic ICD code \_\_\_\_\_
26.  Torticollis ICD code \_\_\_\_\_
27.  OTHER ICD code \_\_\_\_\_  
Rationale for use: \_\_\_\_\_

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

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### DURATION OF THERAPY

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

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### PRECERTIFICATION NOTICE: THE FOLLOWING INDICATIONS ARE NOT COVERED

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**Note:** Priority Health does not cover botulinum toxin for the following indications:

- Botulinum toxin for the treatment of anal spasm, irritable colon, biliary dyskinesia, craniofacial wrinkles or any treatment of other spastic conditions not listed as covered on this prior authorization form are considered experimental (including the treatment of smooth muscle spasm).
- Botulinum toxin for patients receiving aminoglycosides
- Botulinum toxin for patients with chronic paralytic strabismus, except to reduce antagonistic contractor with surgical repair
- Treatment exceeding accepted dosage parameters unless supported by individual medical record review as well as treatments where the goal is to improve appearance rather than function.
- Use of botulinum toxin A or botulinum toxin B for all other conditions not listed above is not a covered benefit.

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

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**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**