Prior Authorization Request Form for Botulinum Toxins

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. Requested:

Please list treatment plan including proposed injection sites and dose that will be injected into each site:

Dates of previous injections:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Does the member have a history of contraindication to the prescribed medication?
☐ Yes
☐ No

Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Botulinum Toxins? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*
☐ Yes
☐ No
Medication Taken Previously (start and end date and dose):_____ [redacted]

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

CHRONIC SPASTICITY:

☐ Member has documented spasticity that:
  ☐ Interferes with daily living, evidenced by:_____
  ☐ Is expected to result in joint contracture with future growth:_____
☐ For member age 18 or older, has documented therapeutic failure, contraindication or intolerance to at least 1 oral medication for spasticity (medication, start date and end date):_____
☐ If member has developed contractures, they have been considered for surgical intervention
☐ Botulinum toxin is requested to:
  ☐ Enhance function:_____
  ☐ Allow for additional therapeutic modalities:_____
☐ Will use botulinum toxin in conjunction with other appropriate therapeutic modalities (physical therapy, occupational therapy, gradual splinting, etc):_____

AXILLARY HYPERHIDROSIS:

- ☐ Documented history of therapeutic failure, contraindication or intolerance to a topical agent (Aluminum Chloride 20%): (medication, start date and end date)_____

CHRONIC MIGRAINE:

- ☐ Member has a history of chronic migraine headache not attributed to other causes including medication overuse:
  - ☐ Number of headache days per month:_____
- ☐ If not prescribed by one of the following specialist neurologist or headache specialist (certified in headache medicine but the United Council for Neurological Subspecialties (UCNS)), please indicate a specialist consulted:_____
- ☐ Documented history of therapeutic failure, contraindication or intolerance to at least 1 migraine preventative medication from following 2 of the following classes: (medication, start date and end date)
  - ☐ Beta-Blocker (e.g. metoprolol, propranolol, timolol):_____
  - ☐ Antidepressant (e.g. amitriptyline, venlafaxine):_____
  - ☐ Anticonvulsant (e.g. topiramate, valproic acid, divalproex):_____

URINARY INCONTINENCE DUE TO DETRUSOR OVERACTIVITY ASSOCIATED WITH NEUROLOGIC CONDITION:

- ☐ Documented history of therapeutic failure, contraindication or intolerance to at least 1 anticholinergic medication used to treat urinary incontinence: (medication, start date and end date)_____

OVERACTIVE BLADDER:

- ☐ Member has overactive bladder with symptoms of urge urinary incontinence, urgency and frequency
- ☐ Documented history of therapeutic failure, contraindication or intolerance to at least 2 agents (e.g., antimuscarinics or beta-3 adrenergic agonists) used to treat overactive bladder: (medication, start date and end date)_____

RENEWAL REQUEST:

- ☐ Request exceeds the recommended FDA dosing and duration of therapy:
  - ☐ Previous treatment was well tolerated but inadequate
  - ☐ Medical literature supports more frequent dosing intervals as safe and effective for the diagnosis and requested dose
- ☐ Request is consistent with the recommended FDA dosing and duration of therapy:
  - ☐ Previous treatment was well tolerated and the member showed a positive clinical response
  - ☐ Symptoms returned to such a degree that repeat injection is required

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)