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/

☐New request ☐Renewal request	Total # of pages _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		Suite #:	City/state/zip:
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Units/package size:	Total quantity requested per treatment:
Injection site(s) & dose per site:		
Diagnosis (*submit documentation*):		Dx code (*required*):
Dates of previous administration and injection sites *(submit documentation)*:		

INITIAL requests

Request for a non-preferred agent: Does the member have a history of trial and failure, contraindication, or intolerance of the preferred Botulinum Toxins that are FDA-approved for the member's diagnosis and age? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes ☐No ☐N/A *Submit documentation of all medications tried and outcomes.*

Complete the sections below that are applicable to the member and this request and SUBMIT DOCUMENTATION for each item.

☐**For a diagnosis of chronic spasticity:**
- ☐Has spasticity that interferes with activities of daily living, evidenced by:_____
- ☐Has spasticity that is expected to result in joint contracture with future growth
- ☐If the member has contractures, has been considered for surgical intervention
- ☐If the member is 18 years of age or older, tried and failed or has a contraindication or an intolerance to an oral medication for spasticity (medication, start and end date):_____
- ☐Botulinum Toxin is being prescribed to enhance function or allow for additional therapeutic modalities to be used
- ☐Will use the requested botulinum toxin in conjunction with other appropriate therapeutic modalities (e.g., PT, OT, gradual splinting, etc.):_____

Rev. 01/2024 v1

☐ **For a diagnosis of axillary hyperhidrosis:**

☐ Tried and failed or has a contraindication or an intolerance to a topical agent such as aluminum chloride 20% solution (medication, start and end date):_____

☐ **For a diagnosis of chronic migraine headache:**

☐ Has a diagnosis of migraine headache consistent with the current International Headache Society Classification of Headache Disorders

☐ Migraine headache is not attributable to other causes, such as medication overuse

☐ Is prescribed the Botulinum Toxin by or in consultation with a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties or a neurologist

☐ Tried and failed or has a contraindication or an intolerance to medications in other drug classes that are used for migraine prevention: (medication, start and end date)

☐ Anticonvulsants (e.g., divalproex, topiramate, valproic acid):_____

☐ Antidepressants (e.g., amitriptyline, venlafaxine):_____

☐ Beta blockers (e.g., metoprolol, propranolol, timolol):_____

☐ **For a diagnosis of urinary incontinence due to detrusor overactivity:**

☐ Has an associated neurologic condition

☐ Tried and failed or has a contraindication or an intolerance to an anticholinergic medication used for the treatment of urinary incontinence (medication, start and end date):_____

☐ **For a diagnosis of overactive bladder:**

☐ Has symptoms of urge urinary incontinence, urgency, and frequency

☐ Tried and failed or has a contraindication or an intolerance to at least 2 medications used for the treatment of overactive bladder (e.g., anticholinergics, beta-3 adrenergic agonists)(medication, start and end date):_____

RENEWAL requests

Check the items below that are applicable to the member and this request and <u>SUBMIT DOCUMENTATION</u> for each item.

☐ Experienced a positive clinical response to the Botulinum Toxin

☐ Symptoms have returned to such a degree that repeat injection with Botulinum Toxin is required

☐ The frequency of injection of Botulinum Toxin exceeds the FDA-approved package labeling

☐ The previous treatment was well-tolerated but inadequate, evidenced by:_____

☐ The requested dose and increased frequency of injection of Botulinum Toxin are supported by medical literature as safe and effective for the diagnosis

ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION

PLEASE <u>FAX</u> COMPLETED FORM WITH <u>REQUIRED CLINICAL DOCUMENTATION</u> TO (844) 205-3386

Prescriber Signature:	**Date**:

<u>Confidentiality Notice</u>: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.

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.)