

**BOTULINUM TOXINS**  
**PRIOR AUTHORIZATION FORM**

To review the prior authorization guidelines for Botulinum Toxins, please refer to Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Botulinum Toxins (accessible at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>)

**PRIOR AUTHORIZATION REQUEST INFORMATION**

New       Renewal       Additional Information (PA#: \_\_\_\_\_)  
# pages in this request: \_\_\_\_\_ Office Contact Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**RECIPIENT INFORMATION**

Name: \_\_\_\_\_ Recipient ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
NPI#: \_\_\_\_\_ OR MA Provider ID#: \_\_\_\_\_ State License#: \_\_\_\_\_  
Prescriber Address: \_\_\_\_\_ Suite #: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
Long-term care facility (if applicable) contact name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**MEDICAL INFORMATION**

**Preferred Agents:**  Botox     Xeomin    **Non-Preferred Agents:**  Dysport     Myobloc

**Strength:** \_\_\_\_\_ **Injection Site & Dose per Site:** \_\_\_\_\_ (submit documentation)

**Diagnosis:** \_\_\_\_\_ (submit documentation) **Diagnosis Code:** \_\_\_\_\_ (required)

**These agents are part of the Specialty Pharmacy Drug Program – which Specialty Pharmacy will be used?**

Diplomat Specialty Pharmacy     Walgreens Specialty Pharmacy

**NON-PREFERRED REQUEST: Has the Recipient tried & failed (or have a contraindication or intolerance to) the Preferred agents: Botox and Xeomin?**     Yes (submit documentation)     No

**INITIAL REQUEST – Please complete the below indication-specific questions**

**1. Axillary Hyperhidrosis:** Has the Recipient tried & failed (or have a contraindication or intolerance to) prescription-strength aluminum chloride anti-perspirant?     Yes (submit documentation)     No

**2. Migraine, Chronic: Check all that apply to the Recipient and submit documentation**

Diagnosed with chronic migraine as per the International Headache Society's Classification of Migraines  
 Tried & failed (or has a contraindication or intolerance to) triptan and/or ergot medications to relieve migraine symptoms  
 Tried & failed (or has a contraindication or intolerance to) an agent in at least 3 of the following medication classes used for migraine prevention:  Anticonvulsants     Beta Blockers     Calcium Channel Blockers     NSAIDs     Tricyclic Antidepressants

**3. Spasticity, Chronic: Check all that apply to the Recipient and submit documentation**

Has spasticity caused by:  cerebral palsy     multiple sclerosis     spinal cord injury     stroke     traumatic brain injury  
 Has spasticity that:  interferes with activities of daily living     is expected to result in joint contracture  
 If the recipient has developed contractures, has been considered for surgical intervention  
 Tried & failed (or has a contraindication or intolerance to) an oral medication for spasticity  
 Drug is being requested to either:  enhance function    or     allow for additional therapeutic modalities to be employed  
 Drug will be used in conjunction with other appropriate therapeutic modalities (such as OT, PT, gradual splinting)

**4. Strabismus: Check all that apply to the Recipient**

Does NOT have Duane's syndrome, restrictive strabismus or strabismus caused by surgery  
 Current deviation measures LESS than 50 prism diopters (submit documentation)

**5. Overactive Bladder (OAB):** Has the Recipient tried & failed (or have a contraindication or intolerance to) at least 2 medications used to treat OAB?     Yes (submit documentation)     No

**6. Urinary Incontinence Due to Detrusor Overactivity Associated with a Neurologic Condition: Has the Recipient tried & failed (or have a contraindication or intolerance to) at least 2 medications used to treat urinary incontinence?**

Yes (submit documentation)     No

**RENEWAL REQUEST – For all indications, please submit documentation supporting the need for a repeat injection**

PLEASE FAX COMPLETED FORM & SUPPORTING CLINICAL INFORMATION TO DHS-PHARMACY DIVISION

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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