Botox Prior Authorization
Form Fax: 1-866-423-0945
Pharmacy Dept. Phone 1-401-427-8200

This form is to be used by participating physicians and providers to obtain coverage. Please complete the form by providing all of the following information. Fax the completed form to Neighborhood at **1-866-423-0945**. For real time Coverage Determination decisions, please go to Cover My Meds: https://www.covermymeds.com/epa/caremark/.

Botox Prior Authorization Form

MEMBER INFORMATION		
Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

PRESCRIBER INFORMATION		
Name and NPI		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

MEDICAL INFORMATION		
Medication/J code:	Strength/Units per dose:	Frequency of Administration:
Dates of Service:	Diagnosis:	

Please select how drug will be obtained (Select one):
☐ Pharmacy Benefit (filled at pharmacy)
☐ Medical Benefit (Buy & Bill) Provider/Facility Name_____ and NPI: _____

***PLEASE NOTE* For Medicaid members botulinum toxin products are covered on the Pharmacy Benefit only.**

Please indicate the Current Procedural Terminology (CPT) codes associated with administration, if needed:
_____

Please note the following CPTs do not require authorization when administered in network:
96372, 64615, 64616, 64642, 64643, 64644, 64645.

Please use the following link for the most up to date information regarding CPT code coverage:
https://www.nhpri.org/providers/prior-authorization-reference-guide-search-tool/

UNIVERSAL CRITERIA

Is the patient on concurrent treatment with another botulinum toxin (i.e., abobotulinumtoxinA, incobotulinumtoxinA, rimabotulinumtoxinB, daxibotulinumtoxina-lanm etc.)? _____

CONTINUATION REQUESTS (please fill out questions below if applicable)

Is the request for continuation of therapy? _____

If yes, please indicate the date the member started on therapy (if known): _____

If yes, is the patient tolerating treatment with Botox: _____

If yes, is the member experiencing an absence of unacceptable toxicity from the drug? _____

INDICATION SPECIFIC QUESTIONS (please fill out questions below based on indented use)

Prophylaxis for Chronic Migraines:

For initial requests:
Is the patient utilizing prophylactic intervention modalities (i.e., pharmacotherapy, behavioral therapy, physical therapy, etc.)? _____
Has the patient had 15 or more headache (tension-type-like and/or migraine-like) days per month for at least 3 months? _____
Has the patient had at least five attacks with features consistent with migraine (with and/or without aura)? _____
On at least 8 days per month for at least 3 months, does the member have headaches with characteristics and symptoms consistent with migraines OR suspected migraines that are relieved by a triptan or ergot derivative medication? _____
Has the patient failed at least an 8-week trial of any two oral medications for the prevention of migraines? (Please list medications) _____

For continuation of therapy:
Has the member had a significant decrease in the number, frequency, and/or intensity of headaches? _____
Has the member had an improvement in function? _____
Does the patient continue to utilize prophylactic intervention modalities (i.e., pharmacotherapy, behavioral therapy, physical therapy, etc.)? _____

Blepharospasms:

For initial requests:
Is the patient at least 12 years of age? _____

For continuation of therapy:
Has the patient had improvement of severity and/or frequency of eyelid spasms? _____

Cervical Dystonia:

For initial requests:
Is the patient at least 16 years of age? _____
Does the patient have a history of recurrent involuntary contraction of one or more muscles in the neck and upper shoulders?
Does the patient have sustained head tilt? _____
Does the patient have abnormal posturing with limited range of motion in the neck? _____

For continuation of therapy:
Does the patient have improvement in the severity and frequency of pain? _____
Doe the patient have improvement of abnormal head positioning? _____

Focal Dystonias:

For initial requests:
Does the patient have focal upper limb dystonia, laryngeal dystonia, or oromandibular dystonia? Please specify.
_____
Has the patient had functional impairment or pain as a result? _____

For continuation of therapy:
For focal upper limb dystonia or oromandibular dystonia, has the member had an improvement in pain and function?
_____
For laryngeal dystonia, has the member had improvement in voice function or quality?
_____

Strabismus:

For initial requests:
Is the patient at least 12 years of age? _____

For continuation of therapy:
Has the patient had improvement in alignment of prism diopters compared to pre-treatment baseline?
_____

Spastic Conditions:

For initial requests:
Please check off if the patient has any of the following:

- ☐ Upper/Lower limb spasticity in adults (i.e., used post-stroke for spasms)
- ☐ Pediatric upper limb spasticity in patients aged 2 years or greater (i.e., used post-stroke for spasms or for spasms related to cerebral palsy)
- ☐ Pediatric lower limb spasticity in patients aged 2 years or greater
- ☐ Spasticity due to multiple sclerosis or Schilder's disease
- ☐ Acquired spasticity secondary to spinal cord or brain injuries
- ☐ Spastic Plegic conditions including Monoplegia, Diplegia, Hemiplegia, Paraplegia (including Hereditary spastic paraplegia) and Quadriplegia
- ☐ Hemifacial Spasm

For continuation of therapy:
Has the patient had a decrease in tone and/or resistance, of affected areas, based on a validated measuring tool (i.e., Ashworth Scale, Physician Global Assessment, Clinical Global Impression (CGI), etc.)?
_____
For patients with Hemifacial Spasms, has the patient had a decrease in frequency and/or severity of spasm, or a decrease in tone and/or improvement in asymmetry to the affected side of the face? _____

Severe Primary Axillary Hyperhidrosis:

For initial requests:
Has the patient tried and failed 1 or more months with topical agents (e.g., aluminum chloride, glycopyrronium, etc)?
Please indicate medications tried_____
Has the patient had a history of medical complications such as skin infections or significant functional impairments?
_____
Has the patient had a significant burden of disease or impact to activities of daily living due to condition (e.g., impairment in work performance/productivity, frequent change of clothing, difficulty in relationships and/or social gatherings, etc)?
_____

For continuation of therapy:
Has the member had a significant reduction in spontaneous axillary sweat production? _____
Has the patient had a significant improvement in activities of daily living? _____

Severe Palmar Hyperhidrosis:

For initial requests:
Has the patient tried and failed 1 or more months with topical agents (e.g., aluminum chloride, glycopyrronium, etc)? _____
Has the patient failed with iontophoresis? _____
Has the patient had a history of medical complications such as skin infections or significant functional impairments; OR has the patient has had a significant impact to activities of daily living due to condition?
_____

For continuation of therapy:
Has the member had a significant reduction in spontaneous palmar sweat production? _____
Has the patient had a significant improvement in activities of daily living? _____

Esophageal Achalasia:

For initial requests:
Is the patient at high risk for complication from pneumatic dilation, surgical myotomy or peroral endoscopic myotomy (POEM)? _____
Has the patient had treatment failure with pneumatic dilation, surgical myotomy, or POEM? _____
Has the patient had perforation from pneumatic dilation? _____
Has the patient had an epiphrenic diverticulum or hiatal hernia? _____
Has the patient had esophageal varices? _____

For continuation of therapy:
Has the member had improvement and/or relief in symptoms (i.e., dysphagia, pain, etc.)?
_____
Has the member had improvement in esophageal emptying as evidenced by functional testing?
_____

Sialorrhea associated with Neurological Disorders:

For initial requests:
Has the patient had a history of troublesome sialorrhea for at least a 3 month period? _____
Does the patient have Parkinson's disease, severe developmental delays, cerebral palsy, or amyotrophic lateral sclerosis? Please specify. _____

For continuation of therapy:
Does the patient have a significant decrease in saliva production? _____

Incontinence due to Detrusor Overactivity:

For initial requests:
Is the patient at least 5 years of age? _____
Does the patient have a current, untreated urinary tract infection? _____
Does the patient have detrusor overactivity associated with a neurologic condition (i.e., spinal cord injury, multiple sclerosis, etc.) that is confirmed by urodynamic testing? _____
Has the patient failed a 1 month or longer trial of two medications from either the antimuscarinic (i.e., darifenacin, fesoterodine, oxybutynin, solifenacin, tolterodine or trospium) or beta-adrenergic (i.e., mirabegron) classes? Please list medications used. _____

For continuation of therapy:
Does the patient have a current, untreated urinary tract infection? _____
Has the patient had significant improvements in weekly frequency of incontinence episodes?
_____
Has the patient's post-void residual (PVR) been periodically assessed as medically appropriate?
_____

Overactive Bladder (OAB):

For initial requests:
Does the patient have a current, untreated urinary tract infection? _____
Does the patient have symptoms of urge urinary incontinence, urgency, and frequency? _____
Has the patient failed a 1 month or longer trial of two medications from either the antimuscarinic (i.e., darifenacin, fesoterodine, oxybutynin, solifenacin, tolterodine or trospium) and/or beta-adrenergic (i.e., mirabegron) classes.
_____

For continuation of therapy:
Does the patient have a current, untreated urinary tract infection? _____
Has the patient had significant improvement in daily frequency of urinary incontinence or micturition episodes and/or volume voided per micturition? _____
Has the patient's post-void residual (PVR) been periodically assessed as medically appropriate?
_____

Chronic Anal Fissure:

For initial requests:
Has other causes of disease been ruled out (i.e., Crohn's Disease, etc)?_____
Has the patient failed on non-pharmacologic supportive measures (i.e., sitz baths, psyllium fiber, bulking agents, etc.)?
_____
Has the patient tried and failed a 1 month or longer trial of conventional pharmacologic therapy (i.e., nifedipine, diltiazem, and/or topical nitroglycerin, bethanechol, etc.)? Please list medications tried.
_____

For continuation of therapy:
Has the member had complete healing of anal fissure? _____
Has the patient had symptomatic improvement of persistent fissures? _____

Ventral Hernia:

For initial requests:
Does the patient have a large ventral hernia with loss of domain or contaminated ventral hernia?
_____
Is the medication being used preoperatively in patients scheduled to receive abdominal wall reconstruction (AWR)?
_____

After filling out the questionnaire, if there is any additional clinical information that you would like to provide, please indicate below. Documentation may also be submitted with this request for review.

_____

_____

_____

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature_____ NPI_____ Date _____