carolina complete health

Pharmacy Request for Prior Approval Botox/Dysport/Myobloc/Xeomin

Recipient Information

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____

Requester Contact Information

Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: ☐ Botox ☐ Dysport ☐ Myobloc ☐ Xeomin 10. Strength:_____ 11. Quantity Requested: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

1. What is the diagnosis or indication for the medication?

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a. ☐ Blepharospasm
b. ☐ Disorders of eye movement (strabismus)
e. ☐ Upper limb spasticity in adults
f. ☐ Severe axillary hyperhidrosis (ANSWER QUESTIONS 2 AND 3 BELOW)
g. ☐ Chronic anal fissure refractory to conservative treatment
h. ☐ Esophageal achalasia recipients in whom surgical treatment is not indicated
i. ☐ Spasticity (e.g., from multiple sclerosis, neuromyelitis optica, other demyelinating diseases of the central nervous system, spastic hemiplegia, quadriplegia , hereditary spastic paraplegia, spinal cord injury, traumatic brain injury, and stroke)
j. ☐ Schilder's disease
m. ☐ Infantile cerebral palsy, specified or unspecified
p. ☐ Secondary focal hyperhidrosis (Frey's syndrome)
r. ☐ Laryngeal dystonia and adductor spasmodic dysphonia
u. ☐ Lower limb spasticity in adults

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c. ☐ Sialorrhea
d. ☐ Spasmodic torticollis, secondary to cervical dystonia
k. ☐ Congenital diplegia – infantile hemiplegia
l. ☐ Achalasia and Cardiospasm
n. ☐ Hemifacial spasms
o. ☐ Symptomatic (acquired) torsion dystonia
q. ☐ Idiopathic (primary or genetic) torsion dystonia
s. ☐ Upper limb spasticity in pediatrics
t. ☐ Lower limb spasticity in pediatrics

2. Does the member have documented medical complications due to hyperhidrosis? ☐ Yes ☐ No List: _____
3. Has the member failed a 6-month trial of conservative management including the use of topical aluminum chloride or extra strength antiperspirant? ☐ Yes ☐ No
List product (s) tried: _____

Botox only

Chronic Migraine (18 and older) New Therapy (approval up to 6 months)

4a. Does the member have 15 or more days each month with headache lasting 4 or more hours? ☐ Yes ☐ No
4b. Has the member tried and failed prophylactic medications from at least 3 different drug classes (beta blockers, calcium channel Blockers, tricyclic antidepressants and anticonvulsants) each for at least 3 months of therapy? ☐ Yes ☐ No List meds tried: _____

Chronic Migraine Continuation of Therapy (approval up to 1 year)

4c. Has the member responded favorably after the first 2 injections? ☐ Yes ☐ No
4d. Has the average number of headache days decreased by 6 or more days from the patient's baseline headache frequency? ☐ Yes ☐ No

Urinary Incontinence (Botox)

5a. Does the member have detrusor over activity associated with neurologic conditions? ☐ Yes ☐ No
5b. Has the member tried and failed an anticholinergic medication? ☐ Yes ☐ No List med tried: _____
5c. Does the member have a documented contraindication, intolerable side effects, or allergy to anticholinergic medications? ☐ Yes ☐ No

Signature of Prescriber:_____ Date:_____

(Prescriber Signature Mandatory)

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.

Fax this form to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/