MC-Rx
Powered by ProCare Rx

Botox®

Ticket #: ____________________ **Request Date:** ______________________ **Request Time:** ______________________

Botox® Prior Authorization Request Form (Page 1 of 3)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Achalasia
- ❑ Chronic anal fissure
- ❑ Chronic back pain
- ❑ Chronic migraine headache
- ❑ Focal hand dystonia
- ❑ Overactive bladder
- ❑ Primary axillary hyperhidrosis
- ❑ Neuromuscular and autonomic disorders
  - Blepharospasm associated with dystonia (e.g., benign essential blepharospasm)
  - Cervical dystonia (also known as spasmodic torticollis)
  - Strabismus
  - Upper or lower limb spasticity
  - VII cranial nerve disorders (hemifacial spasms)
- ❑ Urinary incontinence associated with a neurologic condition
- ❑ Other diagnosis: ______________________________________ ICD-10 Code(s): _________________________________

For achalasia, answer the following:

Is the patient at high risk of complication from or failure to pneumatic dilation OR myotomy? ❑ **Yes** ❑ **No**

Has prior dilation caused esophageal perforation? ❑ **Yes** ❑ **No**

Is the patient at increased risk of dilation-induced perforation due to epiphrenic diverticulum OR hiatal hernia? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had improvement or reduction in symptoms of achalasia (i.e., dysphagia, regurgitation, chest pain)? ❑ **Yes** ❑ **No**

Have at least 6 months elapsed or will have elapsed since the last series of Botox injections? ❑ **Yes** ❑ **No**

For chronic anal fissure, answer the following:

Select if the patient has experienced the following symptoms for at least 2 months:

- ❑ Nocturnal pain and bleeding
- ❑ Post-defecation pain

Does the patient have history of failure, contraindication, or intolerance to conventional therapies including topical nitrates or topical calcium channel blockers (CCBs) (e.g., diltiazem, nifedipine)? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have incomplete healing of fissure or recurrence of fissure? ❑ **Yes** ❑ **No**

Has the patient experienced improvement in symptoms with prior treatment with Botox? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last series of Botox injections? ❑ **Yes** ❑ **No**

Please note that this form is to be completed by the prescribing physician. This document and others, if attached, contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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For chronic back pain, answer the following:

Does the patient have low back pain? ❑ **Yes** ❑ **No**

Has the low back pain lasted for greater than or equal to six (6) months? ❑ **Yes** ❑ **No**

Is Botox prescribed by or in consultation with a neurologist, neurosurgeon, orthopedist, or pain specialist? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to at least one oral NSAID for at least 3 months? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to at least one opioid for at least 3 months? ❑ **Yes** ❑ **No**

Does the patient have history of failure or inadequate response to physical therapy? ❑ **Yes** ❑ **No**

Does the patient have history of failure or inadequate response to nonpharmacologic therapy (e.g., spinal manipulation, massage therapy, transcutaneous electrical nerve stimulation (TENS), acupuncture/acupressure, and surgery)? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation of improvement in the patient's symptoms of chronic back pain with initial Botox treatment? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last treatment with Botox? ❑ **Yes** ❑ **No**

For chronic migraine headache, answer the following:

Select if the patient has chronic migraines, as defined by the following:

- ❑ Greater than or equal to 15 migraine headache days per month
- ❑ Headache lasts 4 hours a day or longer

Is Botox prescribed by or in consultation with a neurologist or pain specialist? ❑ **Yes** ❑ **No**

Select if the patient has history of failure after a trial of at least 2 months, contraindication, or intolerance to the following prophylactic therapies:

- ❑ Antidepressants [i.e., Elavil (amitriptyline), Effexor (venlafaxine)]
- ❑ Antiepileptics [i.e., Depakote/Depakote ER (divalproex sodium), Topamax (topiramate)]
- ❑ Beta-blockers [i.e., atenolol, Inderal (propranolol), nadolol, timolol, Toprol XL (metoprolol)]

Reauthorization:

Has the patient experienced reduction in headache frequency or intensity? ❑ **Yes** ❑ **No**

Is there confirmation the patient has experienced a decrease in the utilization of pain medications (e.g., narcotic analgesics, NSAIDs) or triptans? ❑ **Yes** ❑ **No**

Is there confirmation the patient has experienced a reduction in the number of emergency room visits? ❑ **Yes** ❑ **No**

For neuromuscular and autonomic disorders, answer the following:

Select if the patient has any of the following diagnoses:

- ❑ Blepharospasm associated with dystonia (e.g., benign essential blepharospasm)
- ❑ Cervical dystonia (also known as spasmodic torticollis)
- ❑ Upper or lower limb spasticity
- ❑ Strabismus
- ❑ VII cranial nerve disorders (hemifacial spasms)

Reauthorization:

Is there confirmed improvement in the patient's symptoms with initial Botox treatment? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last treatment with Botox? ❑ **Yes** ❑ **No**

For primary axillary hyperhidrosis, answer the following:

Select the patient's pre-treatment Hyperhidrosis Disease Severity Scale Score (HDSS Score):

- ❑ 1- Patient's underarm sweating is never noticeable and never interferes with daily activities
- ❑ 2- Patient's underarm sweating is tolerable but sometimes interferes with daily activities
- ❑ 3- Patient's underarm sweating is barely tolerable and frequently interferes with daily activities
- ❑ 4- Patient's underarm sweating is intolerable and always interferes with daily activities

Does the patient have skin maceration with secondary infection? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to topical prescription strength drying agents [e.g., Drysol, Hypercare, Xerac AC (aluminum chloride hexahydrate)]? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have at least a 2-point improvement in HDSS (reference the scale provided above)? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last series of Botox injections? ❑ **Yes** ❑ **No**

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For overactive bladder or urinary incontinence associated with a neurologic condition, answer the following:

Select if the patient has one of the following conditions:

- ❑ Urinary incontinence that is associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis)
- ❑ Overactive bladder with symptoms (e.g., urge urinary incontinence, urgency, and frequency)

Is Botox prescribed by or in consultation with a urologist? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to at least one oral anticholinergic (antispasmodic or antimuscarinic) agent [e.g., Bentyl (dicyclomine), Donnatal (atropine/scopolamine/hyoscyamine/phenobarbital), Levsin/Levsinex (hyoscyamine), Ditropan (oxybutynin), Enablex (darifenacin), or VESIcare (solifenacin)]? ❑ **Yes** ❑ **No**

Is the patient routinely performing clean intermittent self-catheterization (CIC) or is willing/able to perform CIC if he/she has post-void residual (PVR) urine volume greater than 200mL? ❑ **Yes** ❑ **No**

Reauthorization:

Is there confirmed improvement in the patient's symptoms with initial Botox treatment? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last treatment with Botox? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

Please note: This request may be denied unless all required information is received.

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