BOTULINUM TOXINS
PRIOR AUTHORIZATION FORM

(form effective 1/5/21)

Keystone First | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:			Patient ID #:	DOB:
Street address:		Apt #:	City/state/zip:	

PRESCRIBER INFORMATION

Prescriber name:		Specialty:	
State license #:	NPI:		MA Provider ID #:
Street address:		Suite #:	City/state/zip:
Phone:		Fax:	

CLINICAL INFORMATION

Product requested: ☐ Botox (preferred with clinical PA required) ☐ Dysport (preferred with clinical PA required) ☐ Myobloc (non-preferred) ☐ Xeomin (non-preferred)

Strength:	Injection site(s) and dose per site:	Qty requested:
Diagnosis (submit documentation):		DX code (required):

For females of childbearing age, is the patient pregnant or breastfeeding? ☐ Yes ☐ No ☐ N/A

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #:	Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

INITIAL REQUESTS (Complete questions applicable to drug requested and patient's diagnosis):

1. **Request for a non-preferred agent (Myobloc or Xeomin):** Does the patient have a history of trial and failure, contraindication, or intolerance of the preferred Botulinum Toxins that are FDA-approved for the patient's diagnosis and age? Check all that apply. ☐ Botox ☐ Dysport
   ☐ Yes ☐ No ☐ N/A *Submit documentation of all medications tried and outcomes.*

2. **Axillary hyperhydrosis:** Does the patient have a history of trial and failure, contraindication, or intolerance of prescription-strength aluminum chloride antiperspirant?
   ☐ Yes ☐ No *Submit documentation.*

3. **Overactive bladder:** Does the patient have a history of trial and failure, contraindication, or intolerance of at least two other medications used to treat OAB?
   ☐ Yes List medication tried:
   ☐ No *Submit documentation of all medications tried and outcomes.*

4. **Urinary incontinence due to detrusor overactivity associated with a neurologic condition:** Does the patient have a history of trial and failure, contraindication, or intolerance of at least two other medications used to treat urinary incontinence? ☐ Yes ☐ No *Submit documentation of all medications tried and outcomes.*

5. **Migraine, Chronic:** Check all of the following that apply to the patient and submit documentation for each.
   - ☐ Diagnosed with chronic migraine not attributed to other causes, as defined by:
     - ☐ Headache on greater than or equal to 15 days per month for at least 3 months
     - ☐ At least five attacks include at least two of the following (check all that apply)
       - ☐ unilateral location ☐ pulsating quality ☐ moderate or severe intensity
       - ☐ aggravation by or causing avoidance of routine physical activity
     - ☐ During headache, the following occur:
       - ☐ Nausea and/or vomiting ☐ Photophobia and phonophobia
   - ☐ History of trial and failure, contraindication, or intolerance of triptans and/or ergotamine medications to relieve migraine symptoms
   - ☐ History of trial and failure, contraindication, or intolerance of an agent in at least 3 of the following drug classes used for migraine prevention:
     - ☐ anticonvulsants ☐ beta blockers ☐ calcium channel blockers
     - ☐ tricyclic antidepressants

   List medications tried:

6. **Spasticity, Chronic:** Check all of the following that apply to the patient and submit documentation for each.
   - ☐ 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 patient has developed contractures, has been considered for surgical intervention
   - ☐ if ≥ 18 years of age, has tried and failed, or has a contraindication or intolerance of, 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 (e.g., OT, PT, gradual splinting)

   List medications tried:

7. **Strabismus:** Check all of the following that apply to the patient and submit documentation for each.
   - ☐ does NOT have Duane's syndrome, restrictive strabismus, or strabismus caused by surgery
   - ☐ current deviation measures LESS than 50 prism diopters
   - ☐ drug has potential to restore binocular vision

8. **All other diagnoses:** Submit documentation supporting the use of the requested agent for the patient's diagnosis and other treatments tried:

RENEWAL REQUESTS

1. *Submit justification and documentation supporting the need for repeat injection.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: