HEALTH PLANS
UNIVERSITY OF UTAH

MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM

BOTULINUM TOXINS

Botox®, Dysport®, Myobloc®, Xeomin®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Botox® (onabotulinumtoxinA), ☐ Dysport® (abobotulinumtoxinA), ☐ Myobloc® (rimabotulinumtoxinB), ☐ Xeomin® (incobotulinumtoxinA)

Dosing/Frequency:____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have an applicable diagnosis? • Achalasia • Axillary hyperhidrosis • Blepharospasm • Cervical dystonia/spasmodic torticollis • Chronic anal fissures • Chronic migraine • Equinus foot related to cerebral palsy • Facial nerve VII disorder (hemifacial spasm) • Frey's syndrome • Hereditary spastic paraplegia • Idiopathic torsion dystonia • Organic writer's cramp • Orofacial dyskinesia (i.e. jaw closure dystonia) • Overactive bladder • Pyloroplasty efficacy assessment • Refractory sialorrhea • Schilder's disease	☐	☐	**Please provide documentation**

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• Spastic hemiplegia • Spasticity due to multiple sclerosis • Spasticity related to stroke or spinal cord injury • Strabismus • Symptomatic torsion dystonia • Infantile cerebral palsy • Laryngeal spasm or laryngeal dysphonia • Neuromyelitis optica • Urinary incontinence • OTHER			
CHRONIC MIGRAINE			
1. Is the request for Botox®?	☐	☐	
2. Is the member 18 years of age or older?	☐	☐	
3. Does the member have a documented diagnosis of chronic migraine with headaches ≥15 days/month for >3 months?	☐	☐	**Please provide documentation**
4. Have possible rebound headaches from medication use and/or medication overuse been ruled out?	☐	☐	**Please provide documentation**
5. Has the member had a 3-month trial and failure to at least one of the following: • Anticonvulsant (e.g. valproate sodium, topiramate) • Beta-blocker (e.g. propranolol, metoprolol) • Antidepressant (e.g. amitriptyline, venlafaxine) • Angiotensin-converting enzyme (ACE) inhibitor (e.g., lisinopril) • Calcium channel blocker (e.g., verapamil, nifedipine)	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member achieved a positive response to therapy? (for chronic migraine, a positive response is a ≥50% reduction in monthly headache days)	☐	☐	**Please provide documentation**
3. Does the member show a continued medical need for therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM-M015
Origination Date: 01/10/2020
Reviewed/Revised Date: 03/25/2020
Next Review Date: 03/25/21
Current Effective Date: 03/25/2020

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