

Neuromuscular Blocking Agents: Botox/Myobloc/Dysport/Xeomin Prior Authorization Form

Member Information		
1. Member last name:		2. Member first name:
3. Member ID #:	4. Member date of birth:	5. Member gender:
Prescriber Information		
6. Prescribing provider NPI#:		
7. Requester contact information		
Name:		
Phone:		Ext:
Drug Information		
8. Drug name:		9. Strength:
10. Quantity per 30 days:		
11. Length of therapy (in days): <input type="checkbox"/> up to 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days		
Clinical Information		
1. What is the prescribed dosage?		
	Units per	
	Days	
2. What is the diagnosis or indication for the medication?		

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- Blepharospasm (**Botox, Dysport, Xeomin**)
- Disorders of eye movement (strabismus) (**Botox**)
- Spasmodic torticollis, secondary to cervical dystonia (**Botox, Dysport, Myobloc, Xeomin**)
- Spasticity in members age 2 and up (**Botox**)
- Severe axillary hyperhidrosis (ANSWER QUESTIONS 2 AND 3 BELOW) (**Botox, Dysport**)
- Sialorrhea (**Botox, Myobloc**)
- Chronic Sialorrhea in members age 2 and up (**Xeomin**)
- Chronic anal fissure refractory to conservative treatment (**Botox**)
- Esophageal achalasia recipients in whom surgical treatment is not indicated (**Botox**)
- Infantile cerebral palsy, specified or unspecified (**Botox**)
- Hemifacial Spasms (**Botox, Dysport**)
- Laryngeal dystonia and adductor spasmodic dysphonia (**Botox**)
- Upper limb spasticity in adults (Dysport, Xeomin)
- Upper limb spasticity in pediatric members 2 years of age and older, excluding spasticity caused by cerebral palsy (**Dysport**)
- Lower limb spasticity in adults and pediatric members 2 years of age and older (**Dysport**)
- Upper limb spasticity in pediatric members 2 to 17 years of age, excluding spasticity caused by cerebral (**Xeomin**)

3. Does the member have documented medical complications due to hyperhidrosis? Yes No

Please list:

4. 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:

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

5. Does the member have 15 or more days each month with headache lasting 4 or more hours? Yes No

6. 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) (BOTOX)

7. Has the member responded favorably after the first 2 injections? Yes No

8. Has the average number of headache days decreased by 6 or more days from the member's baseline headache frequency? Yes No

Urinary Incontinence (Botox)

9. Does the member have detrusor overactivity associated with neurologic conditions? Yes No

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10. Has the member tried and failed an anticholinergic medication? Yes No

List meds tried:

13. Does the member have a documented contraindication, intolerable side effect, 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 **844-376-2318**

Healthy Blue and Healthy Blue Care Together Pharmacy PA Call Center: **844-594-5072** (Healthy Blue Provider Services) or **833-777-3698** (Healthy Blue Care Together Provider Services)