Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

BOTULINUM TOXIN
Prior Authorization
Botox, Dysport and Xeomin

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.		

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Please indicate the diagnosis on the left and complete the corresponding questions.

□ **Cervical dystonia**	No additional information required for initial request, for reauth provide doc of improvement.
□ **Spasticity (indicate upper or lower limb)**	No additional information required for initial request, for reauth provide doc of improvement.
□ **Blepharospasm**	No additional information required for initial request, for reauth provide doc of improvement.
□ **Strabismus**	No additional information required for initial request, for reauth provide doc of improvement.
□ **Axillary Hyperhidrosis**	Has the member tried and failed 10-20% topical aluminum chloride? □ Yes □ No Is the prescribing physician a dermatologist? □ Yes □ No

☐ **Migraine Headache**	Does the member have headaches occurring on 15 or more days a month for at least 3 consecutive months?	☐Yes ☐No
	Are 8 or more of the total headache days per month considered migraine or probable migraine days?	☐Yes ☐No
	Does the member have at least 4 distinct headache episodes each lasting at least 4 hours a day or longer?	☐Yes ☐No
	Is the member using opioids for greater than 10 days per month?	☐Yes ☐No
	Has the member tried for at least 1 month 2 different migraine headache prophylactic therapies (e.g. anticonvulsants, beta-blockers, tricyclic antidepressants)?	☐Yes ☐No
	Is the prescribing physician a neurologist?	☐Yes ☐No
☐ **Overactive Bladder with urge urinary incontinence, urgency, frequency**	Is the prescribing physician a urologist or fellowship-trained urogynecologist?	☐Yes ☐No
	Have there been greater than 3 urinary urgency incontinence episodes in a 3-day period?	☐Yes ☐No
	Have there been greater than 8 micturitions per day?	☐Yes ☐No
	Has the member had a trial (4 weeks) of 2 anticholinergic medications (e.g. oxybutynin, trospium, tolterodibne, etc.) at recommended doses?	☐Yes ☐No
	Please provide chart documentation showing specific examples of how quality of life is impacted.	☐Included ☐ Not available
☐ **Urinary Incontinence**	Has the member had a trial of an anticholinergic medication (e.g. oxybutynin, trospium, tolterodibne, etc.)?	☐Yes ☐No
☐ **Other**	(Please Specify):_____	

History of Medications Used to Treat Above Condition

☐ No other medications have been used to treat this condition

Medication	Strength	Directions	Dates of Therapy		Reason for Discontinuing
			Start	End	

Please provide any additional information which should be considered in the space below: