BOTULINUM TOXINS PRIOR AUTHORIZATION FORM

(form effective 1/6/2025)

Keystone First Community HealthChoices | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

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):

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 a topical agent such as 20% aluminum chloride?
   ☐ Yes ☐ No *List medications tried.*

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

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 one anticholinergic medication used to treat urinary incontinence? ☐ Yes ☐ No *List medications tried.*

5. **Migraine, Chronic:** Check all of the following that apply to the patient and submit documentation for each.
   - ☐ Has a diagnosis of chronic migraine headache according to the current International Headache Society Classification of Headache Disorders that is not attributed to other causes including medication overuse
   - ☐ The requested agent is prescribed by, or in consultation with, one of the following specialists. Submit documentation of consultation, if applicable.
     ☐ neurologist ☐ headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)
   - ☐ History of trial and failure, contraindication, or intolerance of an agent in at least two of the following drug classes used for migraine prevention:
     ☐ anticonvulsants ☐ beta blockers ☐ antidepressants
     ☐ calcitonin gene-related peptide (CGRP)-targeting migraine preventive therapies
     List medications tried: _____

6. **Spasticity, Chronic:** Check all of the following that apply to the patient and submit documentation for each.
   - ☐ has spasticity that interferes with activities of daily living ☐ has spasticity that is expected to result in joint contracture with future growth
   - ☐ if the patient has developed contractures, has been considered for surgical intervention
   - ☐ if ≥ 18 years of age:
     ☐ has focal spasticity ☐ has tried and failed, or has contraindication or intolerance of, an oral medication for spasticity
     List medications tried: _____
   - ☐ 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)

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

RENEWAL REQUESTS

Check all of the following that apply to the patient and submit documentation for each:

1. Request for frequency of injection that is consistent with the dose and duration of therapy limits:
   - ☐ Patient showed a positive response to the medication
   - ☐ For treatment of chronic migraine headache:
     - ☐ Patient requires repeat injection to reduce the frequency, severity, or duration of symptoms
     - ☐ The requested agent is prescribed by, or in consultation with, one of the following specialists. Submit documentation of consultation, if applicable.
       - ☐ neurologist ☐ headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties (UCNS)
   - ☐ For treatment of all other diagnoses:
     - ☐ Patient's symptoms returned to such a degree that repeat injection is required
2. Request for frequency of injection that exceeds the dose and duration of therapy limits:
   - ☐ Treatment was well tolerated but inadequate.
   - ☐ Peer-reviewed medical literature supports more frequent dosing as safe and effective for the diagnosis and requested dose (submit documentation of peer-reviewed medical literature)

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: