



Prior Authorization Form
Botulinum Toxins (Type A & B)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Botox 100 U vial Myobloc 2500 U (0.5ml vial) 5000 U (1ml vial) 10,000 U (2ml vial)

Quantity Refill x months

Instructions

Physician's signature Provider NPI MD#

Date Date medication needed

Patient Information

Patient's name Patient's address City, State, Zip: Patient's phone # Patient's ID#: DOB

Prescriber Information

Prescribing physician Office address City, State, Zip: Office contact Office # Fax#

Upon approval, delivery is available. Complete section below.

No Delivery Requested Delivery Requested Physician's office Patient's home Member Pick up at pharmacy if benefit available

If delivery is requested, please attach a copy of the RX in order to expedite the process

Primary Diagnosis:

- 333.81 Blepharospasm 333.83 Cervical Dystonia 351.8 Hemifacial spasm 343.0 Infantile cerebral palsy Hyperhydrosis(specify ICD9 code): 378.00 Strabismus 728.85 Spasm of the muscle (secondary diagnosis req'd) 333.6 Focal and segmental limb dystonias Other ICD9:

Please answer the questions below for the requests of the diagnosis of Hyperhydrosis

- a. Is the age of onset of Hyperhydrosis 25 years or less? b. Is focal sweating bilateral and relatively symmetric? c. Does the patient sweat during sleep? d. Does the patient have a positive family history of severe primary focal hyperhydrosis? e. Does the hyperhydrosis significantly impair patient's participation in the daily activities? f. Does the patient have any underlying disease, if Yes please specify

Please add any other supporting medical information that maybe useful in the decision making:

FAX TO (215) 761-9165 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only Document # M F Rx coverage Y N Previous Auth Y N Approved Reviewer Initials Vendor LOB STANDARD - SELECT Auth# Date Coverage effective date Billing Code M / Rx Processor Initials Date From To