



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, address, City, State, Zip, phone #, 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, 378.00 Strabismus, 728.85 Spasm of the muscle, 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

Yes/No checkboxes for questions a-f

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

Blank lines for additional medical information

FAX TO (888) 671-5285 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only

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