



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at [www.mercycareaz.org/providers/complecare-forproviders/pharmacy](http://www.mercycareaz.org/providers/complecare-forproviders/pharmacy)

## Botulinum Toxins Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

**REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis**

Member Information					
Member Name (first & last):		Date of Birth:		Gender:	
				<input type="checkbox"/> Male <input type="checkbox"/> Female	
Member ID:		City:		State:	
				Height:	
				Weight:	
Prescribing Provider Information					
Provider Name (first & last):		Specialty:		NPI#	
				DEA#	
Office Address:		City:		State:	
				Zip Code:	
Office Contact:			Office Phone		Office Fax:
Dispensing Pharmacy Information					
Pharmacy Name:			Pharmacy Phone:		Pharmacy Fax:
Requested Medication Information					
<input type="checkbox"/> Botox	<input type="checkbox"/> Dysport	<input type="checkbox"/> Myobloc	<input type="checkbox"/> Xeomin	<input type="checkbox"/> Other, please specify:	
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one):    Yes    No			ICD-10 Code:		Diagnosis:
What medication(s) have been tried and failed for diagnosis?					
Are there any contraindications to formulary medications? If yes, please specify:					<input type="checkbox"/> Yes <input type="checkbox"/> No
Directions for Use:		Strength:			Dosage Form:
		Quantity:	Day Supply:		Duration of Therapy/Use:
Turn-Around Time for Review					
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> <b>Urgent</b> – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____		
Clinical Information					
<input type="checkbox"/> <b>Migraine Prophylaxis</b>					
<input type="checkbox"/> <b>Botox</b>					
Will Botox be used for prevention of chronic migraine (at least 15 days per month with headaches lasting 4 hours a day or longer)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will requested medication be used concurrently with CGRP antagonist?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
There was inadequate response OR intolerable side effects to at least THREE medications from TWO different classes of migraine headache prophylaxis for at least THREE months (check that apply):			<input type="checkbox"/> Beta-Blockers: propranolol, metoprolol, timolol, atenolol, nadolol <input type="checkbox"/> Anticonvulsant: valproic acid or divalproex, topiramate <input type="checkbox"/> Antidepressants: amitriptyline, venlafaxine <input type="checkbox"/> ACE-Is / ARBs: lisinopril, candesartan, losartan, valsartan <input type="checkbox"/> Calcium Channel Blockers: diltiazem, nifedipine, nimodipine, verapamil		
<input type="checkbox"/> <b>Renewal Request ONLY</b>					
Was migraine headache frequency reduced by at least 7 days per month by end of initial trial?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was migraine headache duration reduced by at least 100 hours per month by end of initial trial?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> <b>Chronic Limb Spasticity</b>					
<input type="checkbox"/> <b>Botox</b>		<input type="checkbox"/> <b>Xeomin</b>		<input type="checkbox"/> <b>Dysport</b>	
Is spasticity due to an injury to the brain or spinal cord, or along with a neurological disorder (for example, stroke, traumatic brain injury, multiple sclerosis, spinal cord injury, cerebral palsy)?				<input type="checkbox"/> Yes <input type="checkbox"/> No	

Does member have upper limb spasticity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have lower limb spasticity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there failure with baclofen AND at least ONE other formulary muscle relaxant such as dantrolene?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there a trial of physical and/or occupational therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Severe Primary Axillary Hyperhidrosis</b>					
<input type="checkbox"/> <b>Botox</b>			<input type="checkbox"/> <b>Dysport</b>		
There was focal, visible, excessive sweating for at least SIX months without apparent cause with TWO of the following (check that apply):			<input type="checkbox"/> Interferes with daily activities <input type="checkbox"/> Bilateral and relatively symmetric <input type="checkbox"/> Onset before 25 years of age <input type="checkbox"/> Focal sweating stops during sleep <input type="checkbox"/> Family history of idiopathic hyperhidrosis <input type="checkbox"/> At least one episode per week		
Was there failure with topical aluminum chloride (hexahydrate)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Neurogenic Bladder</b>					
<input type="checkbox"/> <b>Botox</b>					
Is diagnosis of urinary incontinence due to detrusor overactivity associated with neurologic condition?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there trial of behavioral therapy (for example, bladder training, bladder control strategies, pelvic floor muscle training, fluid management) for at least 8-12 weeks?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there a trial and failure with TWO formulary urinary anticholinergics (for example, oxybutynin, trospium, tolterodine)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Overactive Bladder</b>					
<input type="checkbox"/> <b>Botox</b>					
Was a trial of behavioral therapy (for example, bladder training, bladder control strategies, pelvic floor muscle training, fluid management) for at least 8-12 weeks?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there trial and failure with TWO formulary urinary anticholinergics (for example, oxybutynin, trospium, tolterodine)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Esophageal Achalasia</b>					
<input type="checkbox"/> <b>Botox</b>					
Has member remained symptomatic despite surgical myotomy or pneumatic dilation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member at high surgical risk or is unwilling to undergo surgical myotomy or pneumatic dilation?	
<input type="checkbox"/> <b>Chronic Anal Fissures</b>					
<input type="checkbox"/> <b>Botox</b>					
Was there a trial and failure with nitroglycerin ointment 0.4% (Rectiv) AND bulk fiber supplements OR stool softeners OR sitz baths for at least TWO months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was endoscopy completed to rule out Crohn's disease?	
<input type="checkbox"/> <b>Chronic Sialorrhea</b>					
<input type="checkbox"/> <b>Botox</b>		<input type="checkbox"/> <b>Myobloc</b>		<input type="checkbox"/> <b>Xeomin</b>	
Was there trial and failure with anticholinergic such as glycopyrrolate (pediatric use 3-16) or benztropine (adults)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Focal Spasticity or Equinus Gait due to Cerebral Palsy</b>					
<input type="checkbox"/> <b>Botox</b>			<input type="checkbox"/> <b>Dysport</b>		
Is member enrolled in OR is currently being managed with physical and/or occupational therapy?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records</b>					

[Empty box for chart notes]

**Signature affirms that information given on this form is true and accurate and reflects office notes.**

**Prescribing Provider's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please note: Incomplete forms or forms without the chart notes will be returned**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.  
Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.