



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:		Height:
			<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Member ID:	City:	State:			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
<input type="checkbox"/> Continuation of therapy ONLY:	Was migraine HA frequency reduced by at least 7 days per month by end of initial trial?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Was migraine HA duration reduced by at least 100 hours per month by end of initial trial?			<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					
Migraine Prophylaxis					
<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 TWO medications from TWO different classes of migraine headache prophylaxis for at least TWO 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, nortriptyline, venlafaxine, duloxetine		
Chronic Limb Spasticity					
<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

<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	
<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	
<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	
<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"/> Yes <input type="checkbox"/> No
<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"/> Yes <input type="checkbox"/> No
<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	
<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>				

<b>Signature affirms that information given on this form is true and accurate and reflects office notes.</b>	
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.