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/chp-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: ☐ Male ☐ Female	Height:
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				
☐ Botox	☐ Dysport	☐ Myobloc	☐ Xeomin	☐ 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:			☐ Yes	☐ No
☐ Continuation of therapy ONLY:	Was migraine HA frequency reduced by at least 7 days per month by end of initial trial?		☐ Yes	☐ No
	Was migraine HA duration reduced by at least 100 hours per month by end of initial trial?		☐ Yes	☐ No

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – 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					
☐ **Botox**					
Will Botox be used for prevention of chronic migraine (at least 15 days per month with headaches lasting 4 hours a day or longer)?	☐ Yes	☐ No	Will requested medication be used concurrently with CGRP antagonist?	☐ Yes	☐ 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):	☐ Beta-Blockers: propranolol, metoprolol, timolol, atenolol, nadolol				
	☐ Anticonvulsant: valproic acid or divalproex, topiramate				
	☐ Antidepressants: amitriptyline, nortriptyline, venlafaxine, duloxetine				

Chronic Limb Spasticity					
☐ **Botox**	☐ **Xeomin**	☐ **Dysport**			
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)?				☐ Yes	☐ No
Does member have upper limb spasticity?	☐ Yes	☐ No	Does member have lower limb spasticity?	☐ Yes	☐ No
Was there failure with baclofen AND at least ONE other formulary muscle relaxant such as dantrolene?	☐ Yes	☐ No	Was there a trial of physical and/or occupational therapy?	☐ Yes	☐ No

Severe Primary Axillary Hyperhidrosis					
☐ **Botox**	☐ **Dysport**				
There was focal, visible, excessive sweating for at least SIX months without apparent cause with TWO of the following (check that apply):	☐ Interferes with daily activities ☐ Bilateral and relatively symmetric ☐ Onset before 25 years of age ☐ Focal sweating stops during sleep ☐ Family history of idiopathic hyperhidrosis ☐ At least one episode per week				
Was there failure with topical aluminum chloride (hexahydrate)?				☐ Yes	☐ No
Neurogenic Bladder					
☐ **Botox**					
Is diagnosis of urinary incontinence due to detrusor overactivity associated with neurologic condition?				☐ Yes	☐ 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?				☐ Yes	☐ No
Was there a trial and failure with TWO formulary urinary anticholinergics (for example, oxybutynin, trospium, tolterodine)?				☐ Yes	☐ No
Overactive Bladder					
☐ **Botox**					
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?				☐ Yes	☐ No
Was there trial and failure with TWO formulary urinary anticholinergics (for example, oxybutynin, trospium, tolterodine)?				☐ Yes	☐ No
Esophageal Achalasia					
☐ **Botox**					
Has member remained symptomatic despite surgical myotomy or pneumatic dilation?	☐ Yes	☐ No	Is member at high surgical risk or is unwilling to undergo surgical myotomy or pneumatic dilation?	☐ Yes	☐ No
Chronic Anal Fissures					
☐ **Botox**					
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?	☐ Yes	☐ No	Was endoscopy completed to rule out Crohn's disease?	☐ Yes	☐ No
Chronic Sialorrhea					
☐ **Botox**	☐ **Myobloc**		☐ **Xeomin**		
Was there trial and failure with anticholinergic such as glycopyrrolate (pediatric use 3-16) or benztropine (adults)?				☐ Yes	☐ No
Focal Spasticity or Equinus Gait due to Cerebral Palsy					
☐ **Botox**	☐ **Dysport**				
Is member enrolled in OR is currently being managed with physical and/or occupational therapy?				☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records					

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 833-711-0776 to check the status of a request.