HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

BOTULINUM TOXINS

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:
HPP Member Number:
Date of Birth:
Address:
City, State ZIP:
Patient Primary Phone:
Line of Business: □ Medicaid
□ CHIP

Prescriber Name:
Fax: Phone:
Office Contact:
NPI: Promise ID:
Prescriber PA PROMISe ID:
Address:
City, State ZIP:
Specialty/facility name (if applicable):

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient greater than or equal to 18 years of age with a documented diagnosis of overactive bladder (OAB) with symptoms of urge urinary incontinence?

☐ Yes ☐ No

Q2. Is the patient greater than or equal to 18 years of age with a documented diagnosis of urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis)?

☐ Yes ☐ No

Q3. If the patient has a urinary tract infection (UTI), is the patient being treated with antibiotics before considering treatment with Botox®?

☐ Yes ☐ No

Q4. Due to the risk of urinary retention, is the patient willing and able to initiate catheterization post-treatment, if required?

☐ Yes ☐ No

Q5. Has the patient had an inadequate response to or failure of at least two medications indicated for the treatment of urinary incontinence or overactive bladder (e.g., oxybutynin / oxybutynin ER, tolterodine / tolterodine ER, trospium / trospium ER, etc.)?

☐ Yes ☐ No

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Patient Name: **Prescriber Name:**

Q6. Is the patient greater than or equal to 18 years of age with a documented diagnosis of migraine headaches occurring greater than or equal to 15 days per month with headache lasting 4 hours a day or longer?

☐ Yes ☐ No

Q7. Has the patient had an inadequate response to or failure of at least 3 different classes of prophylactic medications (i.e., beta blockers [such as propranolol, metoprolol], amitriptyline, topiramate, valproic acid or its derivatives, verapamil)?

☐ Yes ☐ No

Q8. Is the patient greater than or equal to 18 years of age with a documented diagnosis of upper or lower limb spasticity where botulinum toxin is being used to decrease the severity of increased muscle tone in muscle groups FDA-approved for treatment (please note, the preferred agent for upper limb spasticity is Xeomin®)?

☐ Yes ☐ No

Q9. Has the patient had a documented failure to control spasticity by conventional therapies (e.g., physical therapy, splinting, bracing) and two systemic antispasticity medications (e.g., dantrolene, diazepam or other benzodiazepenes, tizanidine, baclofen)?

☐ Yes ☐ No

Q10. Is the patient greater than or equal to 16 years of age with a documented diagnosis of cervical dystonia where botulinum toxin is being used to reduce the severity of abnormal head position and neck pain (please note, the preferred agent for cervical dystonia is Xeomin®)?

☐ Yes ☐ No

Q11. Is the patient greater than or equal to 18 years of age with a documented diagnosis of persistent primary axillary hyperhidrosis with a score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS)*?

☐ Yes ☐ No

Q12. Has the patient had an inadequate response to or failure of topical aluminum chloride 20% solution?

☐ Yes ☐ No

Q13. Is the patient greater than or equal to 12 years of age with a documented diagnosis of blepharospasm associated with dystonia?

☐ Yes ☐ No

Q14. Is the patient greater than or equal to 12 years of age with a documented diagnosis of strabismus associated with dystonia?

☐ Yes ☐ No

Q15. Is the patient greater than or equal to 18 years of age with a documented diagnosis of chronic sialorrhea and documented contraindication to or treatment failure of glycopyrrolate and scopolamine (please note, the preferred agent for chronic sialorrhea is Xeomin)?

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☐ Yes ☐ No

Q16. Is the medication being prescribed by or in consultation with a specialist for the condition (e.g., urologist for OAB or urinary incontinence; neurologist for migraine headaches; neurologist or physiatrist for upper limb spasticity, cervical dystonia, or hyperhidrosis; dermatologist, neurologist, or physiatrist for hyperhidrosis; ophthalmologist for blepharospasm or strabismus)?

☐ Yes ☐ No

Q17. Has the prescriber submitted documentation of the proposed injection site(s) and the dose that will be injected into each site?

☐ Yes ☐ No

Q18. Is the dose in accordance with the recommend dosing below and occurring no sooner than every 3 months? I. Overactive bladder – up to 100 units per treatment; II. Urinary incontinence – up to 200 units per treatment; III. Chronic migraine – up to 155 units per treatment; IV. Upper or lower limb spasticity – up to 400 units per treatment; V. Cervical dystonia – up to 300 units per treatment (up to 50 units per site); VI. Hyperhidrosis – up to 100 units per treatment (up to 50 units per axilla); VII. Blepharospasm – up to 200 units per treatment; VIII. Strabismus – up to 25 units per muscle per injection

☐ Yes ☐ No

Q19. Is the dose in accordance with the recommend dosing below and occurring no sooner than every 3 months? A. Overactive bladder – up to 100 units per treatment; B. Urinary incontinence – up to 200 units per treatment; C. Chronic migraine – up to 155 units per treatment; D. Upper or lower limb spasticity – up to 400 units per treatment; E. Cervical dystonia – up to 300 units per treatment (up to 50 units per site); F. Hyperhidrosis – up to 100 units per treatment (up to 50 units per axilla) G. Blepharospasm – up to 200 units per treatment; H. Strabismus – up to 25 units per muscle per injection; I. Chronic sialorrhea – up to 100 units per treatment (no sooner than every 16 weeks)

☐ Yes ☐ No

Q20. Requested Duration:

☐ 3 months

Q21. Additional Comments:

Prescriber Signature

Date

Updated 2018

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