Health Partners Plans

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:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
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 member being treated for a condition where use of a botulinum toxin is a Federal Food and Drug Administration (FDA) approved indication or another medically accepted indication, excluding a cosmetic condition?
Note: The requesting prescriber must provide documentation from the medical record of the diagnosis and, when appropriate, the prior treatment of the approved indications.

☐ Yes ☐ No

Q2. Is documentation of the proposed injection site(s) and the dose that will be injected into each site attached to this request?

☐ Yes ☐ No

Q3. Is the member pregnant or breastfeeding?

☐ Yes ☐ No

Q4. Has this plan authorized this medication in the past for this member (for example, previous authorization is on file under this plan)?

☐ Yes ☐ No

Q5. Is the frequency of injection is consistent with the dosing and duration of therapy limits?

☐ Yes ☐ No

Q6. Do all of the following conditions apply to the member: A) the previous treatment was well tolerated and the member showed evidence of measurable improvement in severity of symptoms, and B) the symptoms returned to such a degree that repeat injection?
Note: The prescriber must submit documentation.

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☐ Yes ☐ No

Q7. Does the frequency of injection exceed the dosing and duration of therapy limits?

☐ Yes ☐ No

Q8. Do all of the following conditions apply to the member: A) the previous treatment was well tolerated but inadequate, and B) medical literature supports more frequent dosing intervals as safe and effective for the diagnosis and requested dose?
Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q9. Are all required documentation attached to this request?

☐ Yes ☐ No

Q10. Is this request for a non-preferred agent?

☐ Yes ☐ No

Q11. Does the member have a documented history of therapeutic failure, contraindication or intolerance of the preferred botulinum toxins approved for the indication?

☐ Yes ☐ No

Q12. Does the member have a diagnosis of chronic spasticity resulting from cerebral palsy, multiple sclerosis, traumatic brain injury, spinal cord injury, or stroke?

☐ Yes ☐ No

Q13. Does the member have documented spasticity that applies to either of the following: A) interferes with activities of daily living, or B) is expected to result in joint contracture with future growth?

☐ Yes ☐ No

Q14. Is the member 18 years of age or older?

☐ Yes ☐ No

Q15. Does the member have documented therapeutic failure, contraindication or intolerance to one oral medication for spasticity?

☐ Yes ☐ No

Q16. Has the member developed contractures?

☐ Yes ☐ No

Q17. Has the member been considered for surgical intervention?

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☐ Yes ☐ No

Q18. Is the requested medication being requested for either of the following: A) enhance function or B) allow for additional therapeutic modalities to be employed?

☐ Yes ☐ No

Q19. Will the requested medication be used in conjunction with other appropriate therapeutic modalities such as physical therapy, occupational therapy, gradual splinting, etc?

☐ Yes ☐ No

Q20. Does the member have a diagnosis of strabismus?

☐ Yes ☐ No

Q21. Does the member have a deviation of less than 50 prism diopters?

☐ Yes ☐ No

Q22. Does the treatment with the requested medication have the potential to restore binocular vision?

☐ Yes ☐ No

Q23. Is the member's strabismus due to Duane's Syndrome with lateral rectus muscle weakness, restrictive strabismus or secondary strabismus caused by prior surgery?

☐ Yes ☐ No

Q24. Is the member 12 years of age or older?

☐ Yes ☐ No

Q25. Does the member have a diagnosis of axillary hyperhidrosis?

☐ Yes ☐ No

Q26. Does the member have a history of therapeutic failure, contraindication or intolerance to a topical agent such as 20 percent aluminum chloride?

☐ Yes ☐ No

Q27. Does the member have a diagnosis of chronic migraine headache?

☐ Yes ☐ No

Q28. Does the member have a history of therapeutic failure, contraindication, or intolerance to at least three migraine prophylaxis medications (e.g. beta-blockers, calcium channel blockers, tricyclic antidepressants or anticonvulsant medications)?

☐ Yes ☐ No

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Q29. Does the member have a history of chronic migraine headache not attributed to other causes including medication overuse?

☐ Yes ☐ No

Q30. Does the member have a history of headache (tension-type and/or migraine) on 15 days or more per month for at least three months?

☐ Yes ☐ No

Q31. Do at least five of these attacks meet at least two of the following conditions: A) unilateral location, B) pulsating quality, C) moderate or severe intensity, and D) aggravation by or causing avoidance of routine physical activity (e.g., walking or climbing stairs)?

☐ Yes ☐ No

Q32. During headache, is at least one of the following set of symptoms present: A) nausea and/or vomiting OR B) photophobia and phonophobia?

☐ Yes ☐ No

Q33. Are headaches treated and relieved by triptan(s) or ergotamine(s) before the expected development of associated symptoms of migraine?

☐ Yes ☐ No

Q34. Does the member have a diagnosis of urinary incontinence due to detrusor over activity associated with a neurologic condition?

☐ Yes ☐ No

Q35. Does the member have a history of therapeutic failure, contraindication, or intolerance to at least two agents used in the treatment of urinary incontinence?

☐ Yes ☐ No

Q36. Does the member have a diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency?

☐ Yes ☐ No

Q37. Does the member have a history of therapeutic failure, contraindication, or intolerance to at least 2 agents used in the treatment of overactive bladder?

☐ Yes ☐ No

Q38. Are all required documentation attached to this request?

☐ Yes ☐ No

Q39. Additional Information:

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Patient Name:	Prescriber Name:

Prescriber Signature

Date

Updated for 2020