



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, 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 prescribed the Botulinum Toxin for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication, excluding a cosmetic condition

Yes No

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

Yes No

Q3. Is the age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

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 consistent with the dosing and duration of therapy limits?

Yes No

Q6. Do all of the following conditions apply to the member: A) Tolerability and a positive response to the medication, and B) the symptoms returned to such a degree that repeat injection is required? Note: The prescriber must submit documentation.

Yes No

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



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Patient Name: Prescriber Name:

Form containing 18 questions (Q8-Q18) with Yes/No checkboxes regarding treatment conditions, documentation, and patient eligibility.

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Q19. Does the member have a diagnosis of axillary hyperhidrosis?
Q20. Does the member have a history of therapeutic failure, contraindication or intolerance to a topical agent such as 20 percent aluminum chloride?
Q21. Does the member have a diagnosis of chronic migraine headache?
Q22. Does the member have a history of therapeutic failure to at least one migraine preventive medication from at least two of the following three classes (e.g. beta-blockers, calcium channel blockers, tricyclic antidepressants or anticonvulsant medications)?
Q23. Does the member have a history of chronic migraine headache not attributed to other causes including medication overuse?
Q24. Does the member have a diagnosis of urinary incontinence due to detrusor over activity associated with a neurologic condition?
Q25. Does the member have a history of therapeutic failure, contraindication, or intolerance to at least one anticholinergic medication used in the treatment of urinary incontinence?
Q26. Does the member have a diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency?
Q27. Does the member have a history of therapeutic failure, contraindication, or intolerance to at least 2 agents (such as antimuscarinics or beta-3 adrenergic agonists) used in the treatment of overactive bladder?
Q28. Are all required documentation attached to this request?
Q29. Requested Duration:

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Patient Name:	Prescriber Name:
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Q30. Additional Information:

Prescriber Signature

Date

Updated for 2022