OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Botox® Prior Authorization Request Form (Page 1 of 3)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Achalasia
- ❑ Chronic anal fissure
- ❑ Chronic back pain
- ❑ Chronic migraine
- ❑ Overactive bladder
- ❑ Primary axillary hyperhidrosis
- ❑ Neuromuscular and autonomic disorders
  - Blepharospasm associated with dystonia (e.g., benign essential blepharospasm)
  - Cervical dystonia (also known as spasmodic torticollis)
  - Strabismus
  - Upper or lower limb spasticity
  - VII cranial nerve disorders (hemifacial spasms)
- ❑ Urinary incontinence associated with a neurologic condition
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

For achalasia, answer the following:

Is the patient at high risk of complication from or failure to pneumatic dilation or myotomy? ❑ **Yes** ❑ **No**

Has prior dilation caused esophageal perforation? ❑ **Yes** ❑ **No**

Is the patient at increased risk of dilation-induced perforation due to epiphrenic diverticulum or hiatal hernia? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had improvement or reduction in symptoms of achalasia (i.e., dysphagia, regurgitation, chest pain)? ❑ **Yes** ❑ **No**

Have at least 6 months elapsed or will have elapsed since the last series of Botox injections? ❑ **Yes** ❑ **No**

For chronic anal fissure, answer the following:

Select if the patient has experienced the following symptoms for at least 2 months:

- ❑ Nocturnal pain and bleeding
- ❑ Post-defecation pain

Does the patient have trial and failure, contraindication, or intolerance to conventional therapies including topical nitrates or topical calcium channel blockers (CCBs) (e.g., diltiazem, nifedipine)? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have incomplete healing of fissure or recurrence of fissure? ❑ **Yes** ❑ **No**

Is there documentation the patient has had a positive clinical response to therapy? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last series of Botox injections? ❑ **Yes** ❑ **No**

Botox® Prior Authorization Request Form (Page 2 of 3)

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For chronic back pain, answer the following:

Does the patient have low back pain? ❑ **Yes** ❑ **No**

Has the low back pain lasted for greater than or equal to six (6) months? ❑ **Yes** ❑ **No**

Is Botox prescribed by or in consultation with a neurologist, neurosurgeon, orthopedist, or pain specialist? ❑ **Yes** ❑ **No**

Has the patient had trial and failure of at least 3 months, contraindication, or intolerance to at least one oral NSAID medication? ❑ **Yes** ❑ **No**

Has the patient had trial and failure of at least 3 months, contraindication, or intolerance to at least one opioid medication? ❑ **Yes** ❑ **No**

Has the patient had trial and failure or inadequate response to physical therapy? ❑ **Yes** ❑ **No**

Has the patient had trial and failure or inadequate response to nonpharmacologic therapy (e.g., spinal manipulation, massage therapy, transcutaneous electrical nerve stimulation (TENS), acupuncture/acupressure, and surgery)? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to therapy? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last series of Botox injections? ❑ **Yes** ❑ **No**

For chronic migraine headache, answer the following:

Has medication overuse headache been considered and potentially offending medication(s) been discontinued? ❑ **Yes** ❑ **No**

Does the patient have greater than or equal to 15 migraine headache days per month, of which at least 8 must be migraine days for at least 3 months? ❑ **Yes** ❑ **No**

Is Botox prescribed by or in consultation with a neurologist or pain specialist? ❑ **Yes** ❑ **No**

Select if the patient has history of failure after a trial of at least 2 months, contraindication, or intolerance to the following prophylactic therapies:

- ❑ Elavil (amitriptyline)
- ❑ Effexor (venlafaxine)
- ❑ Depakote/Depakote ER (divalproex sodium)
- ❑ Topamax (topiramate)
- ❑ Beta blocker: atenolol, propranolol, nadolol, timolol, metoprolol

Reauthorization:

Has the patient experienced a positive response to therapy, as demonstrated by a reduction in headache frequency and/or intensity? ❑ **Yes** ❑ **No**

Have the use of acute migraine medications (e.g., NSAIDS, triptans) decreased since the start of Botox therapy? ❑ **Yes** ❑ **No**

Is Botox prescribed by or in consultation with a neurologist or pain specialist? ❑ **Yes** ❑ **No**

Does the patient continue to be monitored for medication overuse headache (MOH)? ❑ **Yes** ❑ **No**

For neuromuscular and autonomic disorders, answer the following:

Select if the patient has any of the following diagnoses:

- ❑ Blepharospasm associated with dystonia (e.g., benign essential blepharospasm)
- ❑ Cervical dystonia (also known as spasmodic torticollis)
- ❑ Upper or lower limb spasticity
- ❑ Strabismus
- ❑ VII cranial nerve disorders (hemifacial spasms)

Reauthorization:

Is there documentation the patient has had a positive clinical response to Botox therapy? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last treatment with Botox? ❑ **Yes** ❑ **No**

For primary axillary hyperhidrosis, answer the following:

Select the patient's pre-treatment Hyperhidrosis Disease Severity Scale Score (HDSS Score):

- ❑ 1- Patient's underarm sweating is never noticeable and never interferes with daily activities
- ❑ 2- Patient's underarm sweating is tolerable but sometimes interferes with daily activities
- ❑ 3- Patient's underarm sweating is barely tolerable and frequently interferes with daily activities
- ❑ 4- Patient's underarm sweating is intolerable and always interferes with daily activities

Does the patient have skin maceration with secondary infection? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to topical prescription strength drying agents [e.g., Drysol, Hypercare, Xerac AC (aluminum chloride hexahydrate)]? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have at least a 2-point improvement in HDSS (reference the scale provided above)? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last series of Botox injections? ❑ **Yes** ❑ **No**

Botox® Prior Authorization Request Form (Page 3 of 3)

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For overactive bladder or urinary incontinence associated with a neurologic condition, answer the following:

Select if the patient has one of the following conditions:

- ❑ Urinary incontinence that is associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis)
- ❑ Overactive bladder with symptoms (e.g., urge urinary incontinence, urgency, and frequency)

Is Botox prescribed by or in consultation with a urologist? ❑ **Yes** ❑ **No**

Has the patient had trial and failure, contraindication, or intolerance to at least one oral anticholinergic (antispasmodic or antimuscarinic) agent [e.g., Bentyl (dicyclomine), Donnatal (atropine/scopolamine/hyoscyamine/phenobarbital), Levsin/Levsinex (hyoscyamine), Ditropan (oxybutynin), Enablex (darifenacin), or VESIcare (solifenacin)]? ❑ **Yes** ❑ **No**

Is the patient routinely performing clean intermittent self-catheterization (CIC) or is willing/able to perform CIC if he/she has post-void residual (PVR) urine volume greater than 200mL? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had the patient has had a positive clinical response to therapy? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last treatment with Botox? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.