



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit [go.covermymeds.com/OptumRx](http://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)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information <small>(required)</small>
<p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Achalasia</p> <p><input type="checkbox"/> Chronic anal fissure</p> <p><input type="checkbox"/> Chronic back pain</p> <p><input type="checkbox"/> Chronic migraine</p> <p><input type="checkbox"/> Neuromuscular disorders (strabismus, blepharospasm associated with dystonia, upper or lower limb spasticity, VII cranial nerve disorders, cervical dystonia)</p> <p><input type="checkbox"/> Overactive bladder (OAB)</p> <p><input type="checkbox"/> Primary axillary hyperhidrosis</p> <p><input type="checkbox"/> Urinary incontinence due to detrusor sphincter dyssynergia or neurogenic detrusor overactivity</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p><b>For achalasia, answer the following:</b></p> <p>Is the patient at high risk for complication from or failure to pneumatic dilation or myotomy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient experienced esophageal perforation caused by prior dilation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have epiphrenic diverticulum or hiatal hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Reauthorization:</b></p> <p>Is there documentation the patient has experienced improvement or reduction in symptoms of achalasia (e.g., dysphagia, regurgitation, chest pain)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have at least 6 months elapsed or will have elapsed since the last series of Botox injections? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>For chronic anal fissure, answer the following:</b></p> <p>Has the patient experienced symptoms of nocturnal pain and bleeding or post-defecation pain for at least 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Reauthorization:</b></p> <p>Does the patient have incomplete healing of fissure or recurrence of fissure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have improvement in symptoms with prior Botox treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>For chronic back pain, answer the following:</b></p> <p>Does the patient have low back pain that has lasted 6 months or more? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select if Botox is prescribed by the following specialist(s):</p> <p><input type="checkbox"/> Neurologist    <input type="checkbox"/> Neurosurgeon    <input type="checkbox"/> Orthopedist    <input type="checkbox"/> Pain specialist</p> <p><b>Reauthorization:</b></p> <p>Does the patient have confirmed improvement in symptoms with initial Botox treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have at least 3 months elapsed or will have elapsed since the last treatment with Botox? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Botox\_CMS\_2020May-W



## Botox<sup>®</sup> Prior Authorization Request Form (Page 2 of 3)

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### For chronic migraine, answer the following:

Does the patient have greater than or equal to 15 headache days per month?  Yes  No

Does the patient have greater than or equal to 8 migraine days per month?  Yes  No

Does the patient have migraine headaches that last 4 hours or more a day or longer?  Yes  No

Select if Botox is prescribed by or in consultation with one of the following specialists with expertise in the treatment of chronic migraine:

- Headache specialist  Neurologist  Pain specialist

Select the prophylactic therapies the patient has had trial and failure (after a trial of at least two months), contraindication, or intolerance to:

- Antidepressants (i.e., Amitriptyline [Elavil], Effexor [venlafaxine])  
 Antiepileptics (i.e., Depakote/Depakote ER [divalproex sodium], Topamax [topiramate])  
 Beta-blockers (e.g., atenolol, Inderal [propranolol], nadolol, timolol, Toprol XL [metoprolol])

### Reauthorization:

Has the patient experienced a reduction in headache frequency or intensity?  Yes  No

Is there confirmation the patient has had a decrease in the utilization of pain medications (e.g., narcotic analgesics, non-steroidal anti-inflammatory drugs [NSAIDs]) or triptans?  Yes  No

Is there confirmation the patient has had a reduction in the number of emergency room visits?  Yes  No

### For neuromuscular disorders, answer the following:

Select if the patient has one of the following:

- Strabismus  
 Blepharospasm associated with dystonia (e.g., benign essential blepharospasm)  
 Treatment of upper and lower limb spasticity  
 VII cranial nerve disorders (hemifacial spasms)  
 Cervical dystonia

### Reauthorization:

Does the patient have confirmed improvement in symptoms with initial Botox treatment?  Yes  No

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

### For overactive bladder (OAB), answer the following:

Select if the patient has the following symptoms:  Frequency  Urge urinary incontinence  Urgency

Select if Botox is prescribed by the following specialist(s):  Neurologist  Neurosurgeon  Urologist

### Reauthorization:

Does the patient have confirmed improvement in symptoms with initial Botox treatment?  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

### Reauthorization:

Has the patient experienced at least a 2-point improvement in the HDSS (reference the scale provided above)?  Yes  No

### For urinary incontinence due to detrusor sphincter dyssynergia or neurogenic detrusor overactivity, answer the following:

Does the patient have neurogenic detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury [SCI], multiple sclerosis)?  Yes  No

Does the patient have detrusor sphincter dyssynergia (DSD) with spinal cord injury (SCI)?  Yes  No

Select if Botox is prescribed by the following specialist(s):  Neurologist  Neurosurgeon  Urologist

### Reauthorization:

Does the patient have confirmed improvement in symptoms with initial Botox treatment?  Yes  No

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



**Botox® Prior Authorization Request Form (Page 3 of 3)**  
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**Quantity Limit:**

What is the quantity requested per MONTH? \_\_\_\_\_ vials

**What is the reason for exceeding the plan limitations?**

- Titration or loading-dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify:** \_\_\_\_\_
- Other: \_\_\_\_\_

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

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Please note:

This request may be denied unless all required information is received.  
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-844-403-1028.