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
- ❑ Neuromuscular disorders (strabismus, blepharospasm associated with dystonia, upper or lower limb spasticity, VII cranial nerve disorders, cervical dystonia)
- ❑ Overactive bladder (OAB)
- ❑ Primary axillary hyperhidrosis
- ❑ Urinary incontinence due to detrusor sphincter dyssynergia or neurogenic detrusor overactivity
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Medication History:

Select if the patient has history of previous use with the following:

- ❑ Botox
- ❑ Dysport
- ❑ Myobloc
- ❑ Xeomin

For achalasia, answer the following:

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

Has the patient experienced esophageal perforation caused by prior dilation? ❑ **Yes** ❑ **No**

Does the patient have epiphrenic diverticulum or hiatal hernia? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has experienced improvement or reduction in symptoms of achalasia (e.g., 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:

Has the patient experienced symptoms of nocturnal pain and bleeding or post-defecation pain for at least 2 months? ❑ **Yes** ❑ **No**

Reauthorization:

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

Does the patient have improvement in symptoms with prior Botox treatment? ❑ **Yes** ❑ **No**

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For chronic back pain, answer the following:

Does the patient have low back pain that has lasted 6 months or more? ❑ **Yes** ❑ **No**

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

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 chronic migraine, answer the following:

Does the patient have 15 or more migraine headache days per month? ❑ **Yes** ❑ **No**

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

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

Select the prophylactic therapies the patient has had trial and failure, contraindication, or intolerance to for at least 2 months:

- ❑ Antidepressants [i.e., 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:

- ❑ Urge urinary incontinence
- ❑ Urgency
- ❑ Frequency

Is Botox prescribed by a neurologist, neurosurgeon, or urologist? ❑ **Yes** ❑ **No**

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**

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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**

Is Botox prescribed by a neurologist, neurosurgeon, or urologist? ❑ **Yes** ❑ **No**

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**

Quantity limit requests:

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?

_____

_____

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 1-800-527-0531.