

Today's date _____

Date medication needed _____



Prior Authorization Form Botulinum Toxins

ONLY COMPLETED REQUESTS WILL BE REVIEWED

- Botox® 100u vial Dysport® 500u vial Xeomin® (indicate vial size: 50u 100u)
- Myobloc® (indicate vial size: 2500u [0.5ml vial] 5000u [1ml vial] 10,000u [2ml vial])

Patient information

Patient name _____
 Address _____
 City, state, ZIP _____
 Patient telephone # _____
 Patient ID # _____
 Date of birth _____ Height _____ Weight _____

Physician information

Prescribing physician _____
 Office address _____
 City, state, ZIP _____
 Office contact _____
 Office telephone # _____
 Fax # _____ NPI _____

Upon approval, delivery is available by completing the section below.

- N/A – No delivery requested (authorization only – physician will use office supply)
- Delivery requested (indicate where medication should be delivered: Physician's office Patient's home)

****A copy of the prescription must accompany the medication request for delivery.****

1. Physician specialty (required; specify all specialties) _____

2. Diagnosis for drug requested (must include ICD-9):

- | | | |
|--|---|--|
| <input type="checkbox"/> 333.6 Focal/segmental limb dystonias | <input type="checkbox"/> 333.81 Blepharospasm | <input type="checkbox"/> 333.83 Cervical dystonia |
| <input type="checkbox"/> 343.0 Infantile cerebral palsy | <input type="checkbox"/> 351.8 Hemifacial spasm | <input type="checkbox"/> 378.00 Strabismus |
| <input type="checkbox"/> 728.85 Spasm of the muscle (secondary diagnosis required) | | <input type="checkbox"/> Other (specify ICD-9) _____ |

3. Patient medical information:

For hyperhidrosis:

- | | | |
|---|------------------------------|-----------------------------|
| a. Is the age of onset of hyperhidrosis 25 years or less? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Is focal sweating bilateral and relatively symmetric? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Does the patient sweat during sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Does the patient have a positive family history of severe primary focal hyperhidrosis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Does the hyperhidrosis significantly impair the patient's participation in daily activities? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Does the patient have any underlying disease? If yes please specify _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

For migraine or probable migraine:

- | | | |
|--|------------------------------|-----------------------------|
| a. Is the frequency of migraine ≥ 15 days per month? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Does the headache last ≥ 4 hours per day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

4. Patient history (please list any previous or current therapies related to the diagnosis):

Drug name	Dates	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please add any other supporting medical information that may be useful in the decision-making process:

5. Prescription information:

Quantity _____ Refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature _____

Fax completed form to 215-761-9165. Your office will receive a response by fax within two business days.