

Today's date: _____

Date medication needed: _____

Prior Authorization Form - Botulinum Toxins

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Select one: Botox® Dysport® Myobloc® Xeomin® Check one: New start Continued treatment

Number of units to be injected _____

Patient information (please print)

Physician information (please print)

Patient name		Prescribing physician	
Address		Office address	
City, state, ZIP		City, state, ZIP	
Patient telephone #		Office contact	
Patient ID		Office telephone #	
Date of Birth	Weight	Fax #	NPI

No delivery requested; physician will use office supply. Authorization only.

Delivery requested to the physician's office.

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

1) **Diagnosis for drug requested (must include ICD-10):** _____

2) **Patient medical information**

For hyperhidrosis only:

- a. Is the age of onset of hyperhidrosis younger than 25 years of age? Yes No
- b. Is focal sweating bilateral and relatively symmetric? Yes No
- c. Does the patient sweat during sleep? Yes No
- d. Does the patient have a positive family history of severe primary focal hyperhidrosis? Yes No
- e. Does the hyperhidrosis significantly impair the patient's participation in daily activities? Yes No
- f. Does the patient have underlying disease causing hyperhidrosis? If yes, specify: _____ Yes No
- g. Which area will be treated? (e.g., palmar, plantar, axillary) _____
- h. How many units will be injected into each area? _____

For chronic migraine or probable chronic migraine only:

- a. Has a neurologist established the diagnosis of chronic migraine headache? Yes No
- b. Have the migraines occurred at least 15 days per month for at least 3 months? Yes No
- c. Does the migraine last at least 4 hours per day? Yes No
- d. Does the patient have either nausea or sensitivity to light and/or sound with the migraine? Yes No
- e. How does the patient describe the pain associated with the migraine? (Select all that apply)
 - Moderate-to-severe pain intensity
 - Unilateral pain
 - Pain aggravated by movement or that prohibits movement
 - Throbbing pain
- f. Has the patient failed to respond to a 4-week course of at least two agents from the different drug classes listed below? If yes, list the drug(s) and the duration(s) below: Yes No
 - 1. Tricyclic antidepressants; (list drug[s]/duration[s]) _____
 - 2. Serotonin-norepinephrine reuptake inhibitors; (list drug[s]/duration[s]) _____
 - 3. Selective serotonin reuptake inhibitors; (list drug[s]/duration[s]) _____
 - 4. Anticonvulsants; (list drug[s]/duration[s]) _____
 - 5. Beta-blockers; (list drug[s]/duration[s]) _____
 - 6. Calcium channel blockers; (list drug[s]/duration[s]) _____
 - 7. Other drug(s); (list drug[s]/duration[s]) _____

3) **Prescription Information:**

Dosage _____ Frequency _____ Refill x _____ month(s)

Physician's Signature: _____

Please fax this completed form to 215-784-0672.