Botox Prior Authorization Form
Fax: 1-866-423-0945
Pharmacy Dept. Phone 1-401-427-8200

This form is to be used by participating physicians and providers to obtain coverage. Please complete the form by providing all of the following information. Fax the completed form to Neighborhood at **1-866-423-0945**. For real time Coverage Determination decisions, please go to Cover My Meds: https://www.covermymeds.com/epa/caremark/.

Botox Prior Authorization Form

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	
Do you need this request decisioned within 24 hours?		

PRESCRIBER'S INFORMATION		
Name and NPI		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

DIAGNOSIS AND MEDICAL INFORMATION		
Medication/Jcode:	Strength/Units per dose:	Frequency of Administration:
Expected Length of Therapy:	Date(s) of service:	
CPT code:	Drug Allergies:	Diagnosis:

UNIVERSAL CRITERIA (please fill out ALL questions below)			
1	Has the patient been evaluated for any disorder which may contribute to respiratory or swallowing difficulty?	Yes	No
2	Does the patient have a hypersensitivity to any botulinum toxin product?	Yes	No
3	Does the patient have an active infection at the proposed injection site?	Yes	No
4	Is the patient on concurrent treatment with another botulinum toxin (i.e., abobotulinumtoxinA, incobotulinumtoxinA, rimabotulinumtoxinB, etc.)?	Yes	No

CONTINUATION REQUESTS (please fill out questions below if applicable)			
1	Is the request for continuation of therapy? If yes, please indicate the date the member started on therapy: _____ Is the patient tolerating treatment with Botox: _____ Has the patient experienced a positive clinical response with Botox therapy as evidenced by an improvement in disease state? Please explain in specific detail (i.e. decrease in migraine headache frequency, improvement in spasticity tone and/or resistance, improvement in activities of daily living) : _____ _____ _____ _____ _____ _____ _____	Yes Yes	No No

Please fill out indication specific questions below if applicable.			
MIGRAINES			
1	Is the requested medication being used for Chronic Migraines? If yes, how many general headache days per month has the member been experiencing? _____ How many migraine specific headache days per month has the member been experiencing? _____ Will the patient be using prophylactic intervention modalities? Please explain: _____ Please indicate what medications the member has tried and failed in the past for this diagnosis: _____ _____	Yes Yes	No No
DYSTONIAS			
2	Is the requested medication being used for cervical dystonia? If yes, has the patient had a history of recurrent involuntary contraction of one or more muscles in the neck? _____ Does the patient have sustained head tilt or abnormal posturing with limited range of motion in the neck? Please explain: _____ _____	Yes Yes Yes	No No No
3	Is the requested medication being used for Focal Dystonias? If yes, please indicate if the member will be using for focal upper limb dystonia, laryngeal dystonia, or oromandibular dystonia? _____ Does the patient have functional impairment or pain as a result? _____	Yes Yes	No No
SPASTIC CONDITIONS **(upper/lower limb spasticity, acquired spasticity, spastic plegic conditions, hemifacial spasm)**			
4	Is the requested medication being used for Spastic Conditions? If yes, please indicate the cause of spastic conditions (ex: CP, stroke, etc): _____ _____	Yes	No
HYPERHIDROSIS			
5	Is the requested medication being used for severe primary axillary hyperhidrosis? If yes, please indicate what medications the member has tried in the past for this diagnosis: _____ _____ (questions continued on next page)	Yes	No

	Does the patient have a history of medical complications such as skin infections, significant functional impairments, or significant burden of disease or impact to activities of daily living due to condition? Please explain: _____ _____	Yes	No
6	Is the requested medication being used for Severe Palmar Hyperhidrosis? If yes, please indicate what medications the member has tried and failed in the past for this diagnosis: _____ _____ Has the patient failed with iontophoresis? Does the patient have a history of medical complications such as skin infections, significant functional impairments, or significant impact to activities or daily living? Please explain: _____ _____ _____ _____	Yes Yes Yes	No No No
ESOPHAGEAL ACHALASIA			
7	Is the requested medication being used for Esophageal Achalasia? If yes, has the patient had treatment failure with pneumatic dilation, POEM or surgical myotomy? Is the patient at high risk for complications from these procedures? Please explain: _____ _____ _____ Has the patient had perforation from pneumatic dilation? _____ Has the patient had an epiphrenic diverticulum or hiatal hernia? _____ Has the patient had esophageal varices? _____	Yes Yes Yes Yes Yes	No No No No No
SIALORRHEA			
8	Is the requested medication being used for Sialorrhea associated with neurological disorders? If yes, how long has member been experiencing sialorrhea? _____ Does the member have a diagnosis of Parkinson's disease, cerebral palsy, or amyotrophic lateral sclerosis? Please indicate: _____ Does the patient have severe developmental delays? _____	Yes Yes Yes	No No No
ANAL FISSURES			
9	Is the requested medication being used for chronic anal fissures? If yes, have other causes of disease been ruled out (ex: Crohn's disease, etc)? (questions continued on next page)	Yes Yes	No No

	What non-pharmacologic supportive measures have been tried? _____ _____ What pharmacologic supportive measures have been tried? _____ _____		
VENTRAL HERNIA			
10	Is the requested medication being used for ventral hernia?	Yes	No
	If yes, does the patient have a large ventral hernia with loss of domain or contaminated ventral hernia? _____	Yes	No
	Will this medication be used preoperatively in patients scheduled to receive abdominal wall reconstruction (AWR)? _____	Yes	No
OVERACTIVE BLADDER & INCONTINENCE			
11	Is the requested medication being used for overactive bladder?	Yes	No
	If yes, does the member has a current, untreated urinary tract infection?	Yes	No
	Does the patient has symptoms of urge urinary incontinence, urgency, and frequency? _____	Yes	Yes
	What medications for this diagnosis has the member previously tried and failed? _____ _____		
12	Is the requested medication being used for incontinence due to detrusor overactivity?	Yes	No
	If yes, does the member has a current, untreated urinary tract infection?	Yes	No
	Does the patient have detrusor overactivity associated with a neurologic condition (i.e., spinal cord injury, multiple sclerosis, etc.) that is confirmed by urodynamic testing? _____	Yes	No
	What medications for this diagnosis has the member previously tried and failed? _____ _____		
OTHER INDICATIONS			
13	Is the requested medication being used for Blepharospasms?	Yes	No
	Is the requested medication being used for Strabismus?	Yes	No
	Is the requested medication being used for any indication not listed above? If yes, please explain: _____ _____	Yes	No

Neighborhood Health Plan OF RHODE ISLAND™

Formulary Exception Request Form
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After filling out the questionnaire, if there is any additional clinical information that you would like to provide, please indicate below.

_____

_____

_____

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature_____ NPI_____ Date _____