Neighborhood Health Plan OF RHODE ISLAND™

Botox Authorization form
J0585

Tel. 401-427-8200; Fax 844-639-7906

Botox Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: □ Male □Female □Unknown Primary Language: □ English □Spanish □ Other:

REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	□ Initial Request □ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:

ICD 10 Codes:

Clinical Assessment (provide all required information and clinical documentation)	YES	NO
Chronic Migraine (***provide all of the required information***):	☐	☐
The patient has at least 15 headache days per month?	☐	☐
The patient has headaches that last at least 4 hours each?	☐	☐
The patient has been evaluated for medication overuse ('rebound') headaches?	☐	☐
Migraine prophylaxis: Patient has failed a recent trial of an appropriate dose & for an appropriate duration of therapy (each lasting at least 2 months) with at least two (2) prophylactic agents from different drug classes:	☐	☐
Renewals: Patient is tolerating treatment and has demonstrated a decrease by at least seven (7) headache days per month following initiation of therapy.	☐	☐

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Hyperhidrosis (***provide all of the required information***):	☐	☐
Has the patient been diagnosed with severe axillary hyperhidrosis?	☐	☐
Has the patient failed a recent trial of an appropriate dose and for an appropriate duration of therapy with aluminum chloride due to inadequate response or intolerance?	☐	☐
Has the patient failed a recent trial of an appropriate dose and for an appropriate duration of therapy with at least one (1) oral anticholinergic	☐	☐
Documentation is provided of inability to perform age-appropriate daily activities	☐	☐
Patient has a Hyperhidrosis Disease Severity Scale (HDSS) score of 3-4 prior to initiation of therapy?	☐	☐
Renewals: The patient must demonstrate an improvement of patient's HDSS score by at least two (2) following initiation of therapy.		
Overactive bladder or Neurogenic bladder(***provide all of the required information***):	☐	☐
The patient has at least 8 urinations in a 24-hour period?	☐	☐
The patient has at least 2 urinary incontinence episodes in a 24-hours period?	☐	☐
Patient has failed a recent trial of an appropriate dose and appropriate duration of therapy with at least 3 antimuscarinic agents, one of which must be a long-acting agent, due to inadequate response or intolerance; please provide medications and dates of therapy:	☐	☐
Patient is able or willing to self-catheterize?	☐	☐
Patient is not prone to urinary tract infections?	☐	☐
Renewals: The patient must demonstrate a decrease of at least two urinary incontinence episodes per day following initiation of therapy	☐	☐
Blepharospasm or Strabismus or Dystonia or spasticity:	☐	☐
The patient is being treated for blepharospasm or strabismus or dystonia or spasticity AND the patient has not responded to traditional therapy with antispasmodic agents, e.g. baclofen and dantrolene.	☐	☐
NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN		

Signature of Requesting Provider:	Date:

Authorization is not a guarantee of payment. Member must be eligible at time of service.