PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Botox® Prior Authorization Request Form (Page 1 of 3)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			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 headache
- ❑ Focal hand dystonia
- ❑ Overactive bladder
- ❑ Primary axillary hyperhidrosis
- ❑ Neuromuscular and autonomic disorders
  - Blepharospasm associated with dystonia (e.g., benign essential blepharospasm)
  - Cervical dystonia (also known as spasmodic torticollis)
  - Strabismus
  - Upper or lower limb spasticity
  - VII cranial nerve disorders (hemifacial spasms)
- ❑ Urinary incontinence associated with a neurologic condition
- ❑ Other diagnosis:_____ICD-10 Code(s): _____

For achalasia, answer the following:

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

Has prior dilation caused esophageal perforation? ❑ **Yes** ❑ **No**

Is the patient at increased risk of dilation-induced perforation due to epiphrenic diverticulum OR hiatal hernia? ❑ **Yes** ❑ **No**

Reauthorization:

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

Select if the patient has experienced the following symptoms for at least 2 months:

- ❑ Nocturnal pain and bleeding
- ❑ Post-defecation pain

Does the patient have history of failure, contraindication, or intolerance to conventional therapies including topical nitrat es or topical calcium channel blockers (CCBs) (e.g., diltiazem, nifedipine)? ❑ **Yes** ❑ **No**

Reauthorization:

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

Has the patient experienced improvement in symptoms with prior treatment with Botox? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last series of Botox injections? ❑ **Yes** ❑ **No**

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For chronic back pain, answer the following:

Does the patient have low back pain? ❑ **Yes** ❑ **No**

Has the low back pain lasted for greater than or equal to six (6) months? ❑ **Yes** ❑ **No**

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

Does the patient have history of failure, contraindication, or intolerance to at least one oral NSAID for at least 3 months? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to at least one opioid for at least 3 months? ❑ **Yes** ❑ **No**

Does the patient have history of failure or inadequate response to physical therapy? ❑ **Yes** ❑ **No**

Does the patient have history of failure or inadequate response to nonpharmacologic therapy (e.g., spinal manipulation, massage therapy, transcutaneous electrical nerve stimulation (TENS), acupuncture/acupressure, and surgery)? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation of improvement in the patient's symptoms of chronic back pain 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 headache, answer the following:

Select if the patient has chronic migraines, as defined by the following:

- ❑ Greater than or equal to 15 migraine headache days per month
- ❑ Headache lasts 4 hours a day or longer

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

Select if the patient has history of failure after a trial of at least 2 months, contraindication, or intolerance to the foll owing prophylactic therapies:

- ❑ Antidepressants [i.e., Elavil (amitriptyline), Effexor (venlafaxine)]
- ❑ Antiepileptics [i.e., Depakote/Depakote ER (divalproex sodium), Topamax (topiramate)]
- ❑ Beta-blockers [i.e., atenolol, Inderal (propranolol), nadolol, timolol, Toprol XL (metoprolol)]

Reauthorization:

Has the patient experienced reduction in headache frequency or intensity? ❑ **Yes** ❑ **No**

Is there confirmation the patient has experienced a decrease in the utilization of pain medications (e.g., narcotic analgesics, NSAIDs) or triptans? ❑ **Yes** ❑ **No**

Is there confirmation the patient has experienced a reduction in the number of emergency room visits? ❑ **Yes** ❑ **No**

For neuromuscular and autonomic disorders, answer the following:

Select if the patient has any of the following diagnoses:

- ❑ Blepharospasm associated with dystonia (e.g., benign essential blepharospasm)
- ❑ Cervical dystonia (also known as spasmodic torticollis)
- ❑ Upper or lower limb spasticity
- ❑ Strabismus
- ❑ VII cranial nerve disorders (hemifacial spasms)

Reauthorization:

Is there confirmed improvement in the patient's 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**

Does the patient have history of failure, contraindication, or intolerance to topical prescription strength drying agents [e. g., Drysol, Hypercare, Xerac AC (aluminum chloride hexahydrate)]? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have at least a 2-point improvement in HDSS (reference the scale provided above)? ❑ **Yes** ❑ **No**

Have at least 3 months elapsed or will have elapsed since the last series of Botox injections? ❑ **Yes** ❑ **No**

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For overactive bladder or urinary incontinence associated with a neurologic condition, answer the following:

Select if the patient has one of the following conditions:

- ❑ Urinary incontinence that is associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis)
- ❑ Overactive bladder with symptoms (e.g., urge urinary incontinence, urgency, and frequency)

Is Botox prescribed by or in consultation with a urologist? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to at least one oral anticholinergic (antispasmodic or antimuscarinic) agent [e.g., Bentyl (dicyclomine), Donnatal (atropine/scopolamine/hyoscyamine/phenobarbital), Levsin/Levsinex (hyoscyamine), Ditropan (oxybutynin), Enablex (darifenacin), or VESIcare (solifenacin)]? ❑ **Yes** ❑ **No**

Is the patient routinely performing clean intermittent self-catheterization (CIC) or is willing/able to perform CIC if he/she has post-void residual (PVR) urine volume greater than 200mL? ❑ **Yes** ❑ **No**

Reauthorization:

Is there confirmed improvement in the patient's 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**

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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	