MedStar Health

MedStar Health
Pharmacy Services
Phone: 866-822-0750
Fax: 855-862-6517

BOTULINUM TOXIN
Prior Authorization
Botox, Myobloc, Dysport and Xeomin

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_____ ICD-10 Code:_____	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Please indicate the diagnosis on the left and complete the corresponding questions.

□ **Hyperhidrosis**	Has the member tried and failed 10-20% topical aluminum chloride?	□ Yes □ No
	Is the prescribing physician a dermatologist?	□ Yes □ No
□ **Migraine Headache**	Does the member have headaches occurring on 15 or more days a month for at least 3 months?	□ Yes □ No
	Are 8 or more of the total headache days per month considered migraine or probable migraine days?	□ Yes □ No
	Does the member have greater than 4 distinct headache episodes each lasting greater than 4 hours a day or longer?	□ Yes □ No
	Is the member using opioids for greater than 10 days per month?	□ Yes □ No

Page 2		
Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

☐ **Overactive Bladder**	Is the prescribing physician a urologist or fellowship-trained urogynecologist? ☐Yes ☐No Have there been greater than 3 urinary urgency incontinence episodes in a 3-day period? ☐Yes ☐No Have there been greater than 8 micturitions per day? ☐Yes ☐No Has the member tried and failed behavioral therapy? (such as weight loss, dietary changes, exercise) ☐Yes ☐No Please provide chart documentation showing specific examples of how quality of life is impacted. ☐Included ☐ Not available
☐ **Other**	(Please Specify):_____

History of Medications Used to Treat Above Condition

☐ No other medications have been used to treat this condition

Medication	Strength	Directions	Dates of Therapy		Reason for Discontinuing
			Start	End	

Please provide any additional information which should be considered in the space below: