

# BOTOX (clostridium botulinum toxin type A)

## SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

**Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).**

1. What drug is being prescribed?

Botox

2. What is the diagnosis?

Primary axillary hyperhidrosis

Chronic anal fissures

Achalasia

Sphincter of Oddi dysfunction

Spasticity

Excessive salivation secondary to Parkinson's disease

Blepharospasm

Detrusor sphincter dyssynergia due to a spinal cord injury

Chronic migraine

Overactive neurogenic bladder dysfunction

Strabismus associated with dystonia

Dysphagia

Cervical dystonia (e.g., torticollis)

Other \_\_\_\_\_

3. Is the drug being prescribed for cosmetic purposes?

Y

N

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4. Does the patient have any of the following contraindications to the use of Botox, Xeomin or Dysport? Y N

Hypersensitivity to any botulinum toxin preparation or any components of this formulation

Infection at the proposed injection site(s)

Allergy to cow's milk protein

5. Will the patient be monitored for life-threatening symptoms or spread of toxin effect from the injection site (e.g., breathing and swallowing difficulties)? Y N

### ***Please complete section designated for patient's diagnosis***

#### **Section A: Primary axillary hyperhidrosis**

6. Has the patient tried conventional treatments (e.g., topical aluminum chloride solution, iontophoresis) without adequate relief? Y N

#### **Section B: Achalasia**

7. Is the patient a candidate for endoscopic dilation or surgery? Y N

#### **Section C: Spasticity**

8. Does the patient have spasticity in the upper or lower limbs secondary to cerebral palsy, multiple sclerosis, stroke or post-traumatic brain or spinal cord injury? Y N

#### **Section D: Blepharospasm**

9. If request is for Xeomin, has the patient previously received treatment with Botox? Y N

#### **Section E: Chronic migraine**

10. How many days per month does the patient experience headaches? \_\_\_\_\_ Days/Month Y N

11. How long do the headaches last?

#### ***Choose one of the following options:***

Less than 1 hour

4 hours

1 hour

5 hours

2 hours

Greater than 5 hours

3 hours

12. Has the patient completed an adequate trial\* of oral migraine preventative therapy? Y N

***\*Adequate trial = a trial greater than or equal to 8 weeks in length***

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13. Document the oral migraine preventative therapy tried:

- |  |  |
|--|--|
| <input type="checkbox"/> Divalproex sodium (Depakote, Depakote ER) | <input type="checkbox"/> Propranolol, Timolol, Nadolol |
| <input type="checkbox"/> Topiramate (Topamax)                      | <input type="checkbox"/> Nimodipine, Verapamil         |
| <input type="checkbox"/> Gabapentin (Neurontin)                    | <input type="checkbox"/> Naproxen, Other NSAID         |
| <input type="checkbox"/> Amitriptyline (Elavil)                    | <input type="checkbox"/> Other _____                   |

14. Was the patient unable to tolerate or does patient have a contraindication to oral migraine preventative therapy? Y      N

15. Is the request for initial authorization or re-authorization?

- Initial reauthorization (No further questions)       Re-authorization

*\*Only complete the below questions for re-authorization*

16. How many injection cycles has the patient received? \_\_\_\_\_ Injection cycle(s)

17. Has the patient's monthly headache frequency decreased by 50% since starting botulinum toxin therapy? (If No, no further questions) Y      N

18. Has the patient maintained a 50% reduction in monthly headache frequency since starting botulinum toxin therapy? Y      N

**Comments:**

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*I affirm that the information given on this form is accurate as of this date.*

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**Prescriber (or Authorized) Signature and Date:**