



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Botox, Dysport, Myobloc, Xeomin Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. Which drug is being prescribed?

<input type="checkbox"/> Botox	Dose: _____	Frequency: _____
<input type="checkbox"/> Dysport	Dose: _____	Frequency: _____
<input type="checkbox"/> Myobloc	Dose: _____	Frequency: _____
<input type="checkbox"/> Xeomin	Dose: _____	Frequency: _____

2. What is the diagnosis?

<input type="checkbox"/> Chronic migraine	<input type="checkbox"/> Cerebral palsy
<input type="checkbox"/> Blepharospasm	<input type="checkbox"/> Hirschsprung's with internal sphincter achalasia
<input type="checkbox"/> Cervical dystonia (e.g., torticollis)	<input type="checkbox"/> Spastic condition related to stroke, spinal cord injury traumatic brain injury, or hereditary spastic paraplegia
<input type="checkbox"/> Upper limb spasticity	<input type="checkbox"/> Dystonias including idiopathic torsion dystonia, myoclonus dystonia, and oromandibular dystonia
<input type="checkbox"/> Primary axillary hyperhidrosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Strabismus	
<input type="checkbox"/> Esophageal achalasia	
<input type="checkbox"/> Chronic anal fissures	

3. What is the ICD9? _____

4. Is the therapy prescribed for cosmetic purposes? (e.g. treatment of wrinkles)? Yes No

5. Does the patient have any of the following contraindication to the prescribed therapy? Yes No
 - Hypersensitivity to any botulinum toxin preparation or any components of the formulation
 - Infection at the proposed injection site(s)
 - Allergy to cow's milk protein (**Dysport only**)

6. Will the patient be monitored for life-threatening symptoms of spread toxin effect from the injection site (e.g. breathing and swallowing difficulties)? Yes No

7. How old is the patient? _____ years

8. If Xeomin is prescribed, has the patient previously received treatment with Botox? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

9. Has the patient had a prior injection with botulinum? Yes No **If No, skip to diagnosis section*
10. How many course of therapy has the patient previously received (number of injections)? _____

Complete the section below designated for the patient's diagnosis (Sections A-I)

Section A: Diagnosis Chronic migraine

11. Prior to initiating therapy, how many days per month does (did) the patient experience headache?
_____ Days/Month
12. How long do headaches last? (Choose **one** of the following options)
 Less than 1 hour 1 hour 2 hours 3 hours
 4 hours 5 hours Greater than 5 hours
13. Has the patient completed an adequate trial (greater than or equal to 8 weeks) of oral migraine preventative therapy? Yes No **If No, skip to # 15*
14. Document the oral migraine preventative therapy tried:
 Divalproex sodium (Depakote, Depakote ER) Propranolol, Timolol, Nadolol
 Topiramate (Topamax) Nimodipine, Verapamil
 Gabapentin (Neurontin) Naproxen, Other NSAID
 Amitriptyline (Elavil) Other _____
15. Was the patient unable to tolerate or does the patient have a contraindication to oral migraine preventative therapy? Yes No
16. Is the patient currently receiving Botox therapy for chronic migraine? Yes No

Only answer below questions if patient is currently on or has previously received therapy for Chronic migraine

17. Has the patient's monthly headache frequency decreased by 50% since starting Botox therapy?
 Yes No
18. Has the patient maintained a 50% reduction in monthly headache frequency since starting Botox therapy? Yes No

Section B: Diagnosis Upper Limb spasticity

19. Botox prescribed to treat spasticity of the elbow, hands, or fingers? Yes No

Section C: Diagnosis Primary axillary hyperhidrosis

20. Has the patient tried conventional treatments (e.g., topical aluminum chloride, iontophoresis) without adequate relief? Yes No

Section D: Diagnosis Esophageal achalasia

21. Has the patient had a previous trial and failure to conventional therapy (e.g. calcium channel blockers [CCB], nitrates? Yes No
22. Is the patient a good candidate for pneumatic dilation or myotomy? Yes No

Section E: Diagnosis Cerebral palsy

24. Does the patient have focal increased muscle tone that interferes with function or is likely to lead to joint contracture with growth? Yes No

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Section F: Diagnosis Chronic anal fissures

23. Has the patient tried at least 2 months of one or more of following conventional therapies and failed?
 Yes No Diet modifications Stool Softner Warm sitz baths
 Bulk fiber supplements Nitroglycerin 0.2% ointment

Section G: Diagnosis Cerebral palsy

24. Does the patient have focal increased muscle tone that interferes with function or is likely to lead to joint contracture with growth? Yes No

Section H: Diagnosis Spastic condition related to stroke, spinal cord injury, traumatic brain injury, or hereditary spastic paraplegia

25. Is the patient's spastic condition refractory to one or more of the following conventional therapies?
 Yes No Baclofen Benzodiazepines Dantrolene sodium
 Tizanidine Physical therapy

Section I: Diagnosis Dystonias including idiopathic torsion dystonia, myoclonus dystonia, and oromandibular dystonia

26. Has the patient had a trial with carbidopa/levodopa followed by a trial of trihexyphenidyl?
 Yes No

****NOTE: We can NOT make a decision without a copy of the documentation - Thank You****

Information given on this form is accurate as of this date:

X

Prescriber or Authorized Signature

Date (mm/dd/yy)

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