BOTULINUM TOXINS PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Botulinum Toxins** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html

☐New request ☐Renewal request	Total # of pages _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Units/package size:	Total quantity requested per treatment:
Injection site(s) & dose per site:		
Diagnosis (*submit documentation*):		Dx code (*required*):
Dates of previous administration and injection sites *(submit documentation)*:		

Complete all sections that apply to the member and this request.
Check all that apply and SUBMIT DOCUMENTATION for each item.

INITIAL requests

☐**For a NON-PREFERRED Botulinum Toxin:**
- ☐Has a history of trial and failure of or a contraindication or an intolerance to the preferred Botulinum Toxins that are approved or medically accepted for treatment of the member's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.):*_____

☐**For a diagnosis of CHRONIC SPASTICITY:**
- ☐Has spasticity that interferes with activities of daily living
- ☐Has spasticity that is expected to result in joint contracture with future growth

☐ If the member has contractures, has been considered for surgical intervention
☐ One of the following:
  ☐ Has focal spasticity
  ☐ Is under 18 years of age
  ☐ Is 18 years of age or older and tried and failed or has a contraindication or an intolerance to an oral medication for spasticity:_____
☐ Botulinum Toxin is prescribed to enhance function or allow for additional therapeutic modalities to be used
☐ Will use the requested botulinum toxin in conjunction with other appropriate therapeutic modalities (e.g., PT, OT, gradual splinting, etc.):_____

☐ **For a diagnosis of AXILLARY HYPERHIDROSIS:**
☐ Tried and failed or has a contraindication or an intolerance to a topical agent such as aluminum chloride 20% solution

☐ **For a diagnosis of CHRONIC MIGRAINE HEADACHE:**
☐ Has a diagnosis of migraine headache consistent with the current International Headache Society Classification of Headache Disorders
☐ Migraine headache is not attributable to other causes, such as medication overuse
☐ Is prescribed the Botulinum Toxin by or in consultation with a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties or a neurologist
☐ Tried and failed or has a contraindication or an intolerance to at least one drug used for migraine prevention from at least 2 of the following classes:
  ☐ Anticonvulsants (e.g., divalproex, topiramate, valproic acid):_____
  ☐ Antidepressants (e.g., amitriptyline, venlafaxine):_____
  ☐ Beta blockers (e.g., metoprolol, propranolol, timolol):_____
  ☐ CGRP-targeting migraine preventive therapies (e.g., gepants, monoclonal antibodies):_____

☐ **For a diagnosis of URINARY INCONTINENCE due to detrusor overactivity:**
☐ Has an associated neurologic condition
☐ Tried and failed or has a contraindication or an intolerance to an anticholinergic drug used for the treatment of urinary incontinence (e.g., darifenacin, fesoterodine, oxybutynin, solifenacin, tolterodine, trospium):_____

☐ **For a diagnosis of OVERACTIVE BLADDER:**
☐ Has symptoms of urge urinary incontinence, urgency, and frequency
☐ Tried and failed or has a contraindication or an intolerance to at least 2 drugs used for the treatment of overactive bladder (e.g., anticholinergics, beta-3 adrenergic agonists):_____

RENEWAL requests

☐ Experienced a positive clinical response to the Botulinum Toxin
☐ One of the following:
  ☐ For the treatment of chronic migraine headache, requires repeat injection to reduce the frequency, severity, or duration of symptoms
  ☐ For the treatment of all other diagnoses, has symptoms that returned to such a degree that repeat injection with Botulinum Toxin is required
☐ The frequency of injection of Botulinum Toxin exceeds the FDA-approved package labeling
  ☐ The previous treatment was well-tolerated but inadequate
  ☐ The requested dose and increased frequency of injection of Botulinum Toxin are supported by medical literature as safe and effective for the diagnosis

☐ **For a diagnosis of CHRONIC MIGRAINE HEADACHE:**
☐ Is prescribed the Botulinum Toxin by or in consultation with a headache specialist who is certified in headache medicine by the United

Council for Neurologic Subspecialties or a neurologist

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)