AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Neuromuscular Blocking Agents: Botox/Dysport/Myobloc/Xeomin

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Requested: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___270 days ___365 days

Clinical Information

1. What is the prescribed dosage? _____units per _____days
2. What is the diagnosis or indication for the medication?

Botox:

☐ Disorders of eye movement (strabismus)
☐ Spasticity in beneficiaries age 2 and up
☐ Chronic anal fissure refractory to conservative treatment
☐ Esophageal achalasia recipients in whom surgical treatment is not indicated
☐ Infantile cerebral palsy, specified or unspecified
☐ Laryngeal dystonia and adductor spasmodic dysphonia

Dysport:

☐ Upper limb spasticity in pediatric beneficiaries 2 years of age and older, excluding spasticity caused by cerebral palsy
☐ Lower limb spasticity in adults and pediatric beneficiaries 2 years of age and older

Xeomin:

☐ Chronic Sialorrhea in beneficiaries age 2 and up
☐ Upper limb spasticity in pediatric beneficiaries 2 to 17 years of age, excluding spasticity caused by cerebral palsy

Botox, Dysport:

☐ Severe axillary hyperhidrosis **(ANSWER QUESTIONS 3 & 4 BELOW)**
☐ Hemifacial Spasms

Botox, Dysport, Myobloc, Xeomin:

☐ Spasmodic torticollis, secondary to cervical dystonia

Botox, Myobloc:

☐ Sialorrhea

Dysport, Xeomin:

☐ Upper limb spasticity in adults

Botox, Dysport, Xeomin:

☐ Blepharospasm

3. Does the patient have documented medical complications due to hyperhidrosis? Yes___ No___
If yes, explain: _____
4. Has the patient failed a 6-month trial of conservative management including the use of topical aluminum chloride or extra strength antiperspirant? Yes___ No___ If yes, list products tried: _____

Botox only

Chronic Migraine (18 and older) New Therapy (approval up to 6 months):

5. Does the patient have 15 or more days each month with headache lasting 4 or more hours? Yes___ No___
6. Has the patient tried and failed prophylactic medications from at least 3 different drug classes (beta blockers, calcium channel blockers, tricyclic antidepressants and anticonvulsants) each for at least 3 months of therapy? Yes___ No___
List meds tried: _____
7. Does the beneficiary have a documented contraindication, intolerable side effect, or allergy to anticholinergic medications? Yes___ No___

Chronic Migraine Continuation of Therapy (approval up to 1 year):

8. Has the patient responded favorably after the first 2 injections? Yes___ No___
9. Has the average number of headache days decreased by 6 or more days from the patient's baseline headache frequency? Yes___ No___

Urinary Incontinence:

10. Does the patient have detrusor overactivity associated with neurologic conditions? Yes___ No___
11. Has the patient tried and failed an anticholinergic medication? Yes___ No___ **List med tried**: _____
12. Does the patient have a documented contraindication, intolerable side effects, or allergy to anticholinergic medications? Yes___ No___

Overactive Bladder:

13. Has the beneficiary tried and failed 2 anticholinergic medications? Yes___ No___ **List meds tried**: _____
14. Does the beneficiary have a documented contraindication, intolerable side effect, or allergy to anticholinergic medications? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406