BOTULINUM TOXIN AUTHORIZATION AND REAUTHORIZATION

15 Earhart Drive, Suite 101, Amherst, NY 14221

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Member Name:	Today's Date:	Date Needed:	
Date of birth: Sex: Weight:		Prescriber:	Hospital/Clinic:
Home Phone Number: ( )		Phone Number: ( )	Fax Number: ( )
Home Address:	City: State: Zip:	Address:	City: State: Zip:
Payor: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions Insurance ID:	☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-funded Group Number:	Prescriber specialty: Allergies:	

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD10 Code _____

OTHER DIAGNOSIS/ICD10 CODE: _____

- Has Functional Impairment been demonstrated with this condition? ☐ Yes ☐No
- Please submit office visit notes to support this diagnosis

FOR ALL DIAGNOSES: Please state all medications tried and failed for this condition, as well as response to treatment: _____

_____

_____

FOR CHRONIC MIGRAINE:

Please submit headache diary, with record of headache frequency and analgesic usage for the three prior months, or office notes detailing the frequency and severity of patient's headaches:

- Will patient be using botulinum toxin in combination with a CGRP receptor antagonist? ☐ Yes ☐No

IF YES:

- Has patient had a reduction in overall migraine days or reduction in number of severe migraine days per month with CGRP use? ☐ Yes ☐No
- Does Patient continue to experience a significant number of migraine headache days or severe migraine days per month requiring additional therapy for migraine prevention? ☐ Yes ☐ No

FOR CHRONIC MIGRAINE REAUTHORIZATION:

- Please submit updated Headache Diary or Office Notes documenting at least 50% improvement from baseline
- Is the patient using concurrently with a CGRP Receptor antagonist? ☐ Yes ☐ No

IF YES:

- Has the patient had further reduction in the overall number of migraine days or reduction in number of severe migraine days per month compared to monotherapy with the initial agent? ☐ Yes ☐ No

DRUG SELECTION

☐ New Authorization ☐ Reauthorization*

☐ Botox ☐ Dysport

☐ Myobloc

Dose: _____ Frequency: _____

Estimated Start of Therapy: _____

FOR DYSPORT AND MYOBLOC ONLY:

- Has the patient tried and failed, or have a contraindication to both Botox and Xeomin? ☐ Yes ☐ No

PRIMARY AXILLARY HYPERHIDROSIS:

- Is inadequately managed with topical agents where the excessive sweating results in a functional deficit? ☐ Yes ☐ No
- Has the patient tried and failed a reasonable trial of aluminum chloride 20% topical solution? ☐ Yes ☐ No

OAB WITH URINARY INCONTINENCE

- Has the patient had an inadequate response or intolerance to an anticholinergic medication? ☐ Yes ☐ No

URINARY INCONTINENCE DUE TO DETRUSOR ACTIVITY DUE TO A NEUROLOGIC CONDITION

- Has the patient had an inadequate response or intolerance to an anticholinergic medication? ☐ Yes ☐ No

FOR REAUTHORIZATION:

- Has the patient had a positive response to treatment? ☐ Yes ☐No
- Please Submit updated office notes documenting response and treatment plan