

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Botulinum Toxin A (Botox®) & Toxin B (Myobloc™)
PreDetermination of Medical Benefits

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

Click on grey boxes to type	Request Date:	/ /
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<input type="checkbox"/> Initial Authorization Request	<input type="checkbox"/> Subsequent Request; List Prior Auth Ref #:
<input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800.870.6419)	

1. PATIENT INFORMATION

Patient Last Name	Patient First Name	Anthem Member ID Number	Patient DOB / /
Contact Phone Number () -	Primary Diagnosis	ICD-9 Code(s)	Patient's Weight (lbs) Date: _____

2. PHYSICIAN INFORMATION

Physician Last Name	Physician First Name	Physician DEA or NPI Number	Physician Tax ID
Address	City	State	Zip Code
Office Phone Number () -	Office Fax Number () -	Office Contact Name	Physician Specialty

3. MEDICATION INFORMATION

Drug Name <input type="checkbox"/> Botox (toxin A) <input type="checkbox"/> Myobloc (toxin B)	HCPCS or CPT Code(s) <input type="checkbox"/> J0585 <input type="checkbox"/> J0587	Strength / Dose	
Direction for Use (SIG)			
Date patient is scheduled to be treated (need by date) / /	Service From Date / /	Service Thru Date / /	Number of Refills
Ship Medication to: <input type="checkbox"/> MD Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other: (please specify)			

4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: To avoid delays, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended. If Indicated, please provide ALL supporting lab results, progress notes, etc.

(1) Disorders Associated with Spasticity or Dystonia

Yes No Does patient have one or more of the following disorders associated with spasticity or dystonia? (check all that applies)

<input type="checkbox"/> Blepharospasm	<input type="checkbox"/> Spasticity related to stroke, or spinal cord injury
<input type="checkbox"/> Equines foot related to cerebral palsy	<input type="checkbox"/> Idiopathic torsion dystonia
<input type="checkbox"/> Hereditary spastic paraplegia	<input type="checkbox"/> Organic writer's cramp
<input type="checkbox"/> Infantile cerebral palsy	<input type="checkbox"/> Orofacial dyskinesia (e.g. jaw closure dystonia)
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Spasmodic dystonia or laryngeal dystonia
<input type="checkbox"/> Neuromyelitis optica	<input type="checkbox"/> Symptomatic torsion dystonia
<input type="checkbox"/> Schilder's disease	<input type="checkbox"/> Facial nerve (VII) dystonia
<input type="checkbox"/> Spastic hemiplegia	<input type="checkbox"/> Other forms of upper motor neuron spasticity

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY (continue)

(2) Cervical Dystonia (spasmodic torticollis)

For Initial Treatment

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- Yes No Is patient diagnosed with cervical dystonia?
- Yes No Does patient have h/o recurrent clonic and/or tonic involuntary contractions of one or more of the following muscles: sternocleidomastoid, splenius, trapezius, and/or posterior cervical muscles?
- Yes No Does patient have sustained head tilt and/or abnormal posturing with limited range of motion in the neck?
- Yes No Has the condition persisted for greater than 6 months?

For Subsequent Treatments

- Yes No Did patient respond to the initial treatment (documented in the medical records)?
- Yes No Does patient still meet criteria listed under Initial Treatment?

(3) Other Diagnoses

- Yes No Is patient diagnosed with any of the following? (check all that applies)
 - Strabismus
 - Achalasia
 - Chronic anal fissures
 - Incontinence related to detrusor overactivity
 - Incontinence of neurogenic origin (e.g. spinal cord injury)
 - Bladder detrusor sphincter dyssynergia
 - Excessive drooling (and intolerant to scopolamine)

(4) Hyperhidrosis

- Yes No Is patient diagnosed with primary hyperhidrosis?
- Yes No Does patient have medical complications or skin maceration with secondary infection?
- Yes No Does patient pt have significant functional impairment (documented in the medical records)?
- Yes No Has patient been on any of the following non-surgical treatments for at least 6 months and clinical improvement was not achieved?
 - Topical dermatologics (e.g. aluminum chloride, tannic acid)
 - Systemic anticholinergics
 - Tranquilizers
 - Non-steroidal anti-inflammatory drugs
- Yes No Does patient have secondary hyperhidrosis related to surgical complications?
- Yes No Does patient have secondary hyperhidrosis with significant functional impairment?

(5) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

5. PHYSICIAN SIGNATURE

Prescriber's or Authorized Representative's Signature:

Date: ____ / ____ / ____

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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Medical Policy Reference can be found at: www.bcbsga.com

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