Outpatient Medical Injectables
Botulinum Toxin
Request Form. Fax to 833-581-1861
(Medical Benefit Only)

Member Name: _____DOB: _____ID (UMI): _____ ☐ Medicare ☐ Commercial*

Ordering/Attending Provider Name: _____NPI Number: _____

Ordering/Attending Provider Address:_____

Office Contact: _____Phone #:_____Fax #:_____

Servicing Facility/Vendor Name: _____Facility NPI:_____

Servicing Facility/Vendor Address:_____

ICD10 Diagnosis Code(s): _____Requested Start Date of Service: _____

*For providers in Western PA and West Virginia, the specialty pharmacy will be assigned by Free Market Health. All other providers, please specify below:

☐ **Buy & Bill** ☐ **Drug Supplied by Specialty Pharmacy** *(Pharmacy Name: _____ NPI: _____)*

☐ BOTOX (J0585) ☐ DYSPORT (J0586) ☐ MYBLOC (J0587) ☐ XEOMIN (J0588)

☐ OTHER _____ (J_____)

Dose or number of units: _____ Frequency: _____ Number of visits requested: _____

FOR CHRONIC MIGRAINE
How many days a month does the member experience headache?
When the member experiences migraines, how many hours a day do they last?
For how long has the member been experiencing migraine headaches?
Is this request prescribed by or in consultation with a neurologist or headache specialist? ☐ YES ☐ NO
Is a healthcare provider trained in administration of botox administering the drug? ☐ YES ☐ NO
Has the diagnosis of chronic migraine headache been established using the International Classification of Headache Disorders, Third Edition? (ICHD-III) ☐ YES ☐ NO
Has there been a persistent three month history of recrurring debilitating headache documented by the member via headache diary or calendar? ☐ YES ☐ NO
Are headaches caused by medication rebound or lifestyle issues? ☐ YES ☐ NO
Has the member tried and failed adequate trials of prophylactic therapy from **at least two different therapy classes** (ex: antiseizure, beta blocker, tricyclic antidepressant)? ☐ YES ☐ NO • Please list all previous prophylactic therapies tried and failed, not tolerated or contraindicated: • Were the above medications prescribed at adequate doses for reasonable lengths of time (ex: 6 weeks each)? ☐ YES ☐ NO

****Please verify member's eligibility and benefits through the health plan****

FOR CHRONIC MIGRAINE	
☐ **New Start**	☐ **Continuation of Therapy** Since starting Botox has the member's migraine headache **frequency** reduced by at least **50%** from baseline? ☐ YES ☐ NO Since starting Botox has the member's migraine headache **hours** reduced by at least **50%** from baseline? ☐ YES ☐ NO

FOR HYPERHIDROSIS
Does the member have **severe** hyperidrosis? ☐ YES ☐ NO
Please indicate which focal region the botulinum toxin will be treating: *(circle all that apply)* Axillary Region Palmar Region Plantar Region Craniofacial Region Other: _____
Please indicate if the member has experienced any of the following: • History of recurrent skin maceration with bacterial or fungal infections? ☐ YES ☐ NO • History of atopic dermatitis (atopic eczema) despite medical treatments with topical dermatological or systemic anticholinergic agents? ☐ YES ☐ NO
Has the member been unresponsive or unable to tolerate pharmacotherapy modalities prescribed for excessive sweating (ex: anticholinergics, beta-blockers, or benzodiazepines)? ☐ YES ☐ NO
Have topical products such as 20% aluminum chloride or other extra strength antiperspirants been ineffective or resulted in a severe rash? ☐ YES ☐ NO

☐ **New Start**	☐ **Continuation of Therapy** Since starting botulinum toxin, is there a documented objective measurable effect indicating a positive clinical response to treatment (ex: improvement in HDSS)? ☐ YES *please describe*: _____ ☐ NO

FOR ALL OTHER USES
Please list all other therapies tried and failed, not tolerated, or contraindicated for the diagnosis: _____

☐ **New Start**	☐ **Continuation of Therapy** Has the member had a documented positive clinical response to treatment? ☐ YES ☐ NO

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**