



Outpatient Medical Injectables
Botulinum Toxin
Request Form. Fax to 833-619-5745
(Medical Benefit Only)

Member Name: _____ DOB: _____ UMI: _____ Medicare Commercial

Requesting Physician's Name: _____ NPI Number: _____

Requesting Physician's Address: _____

Office Contact: _____ Phone #: _____ Fax #: _____

Facility: _____ Facility NPI Number: _____

Facility's Address: _____

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

Supplied by Alliance Rx Walgreens Specialty Pharmacy Buy & Bill Other _____

Form with checkboxes for BOTOX (J0585), DYSPORT (J0586), MYBLOC (J0587), XEOMIN (J0588), and OTHER (J_____)

FOR CHRONIC MIGRAINE

Series of questions regarding 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? Is a healthcare provider trained in administration of botox administering the drug? Has the diagnosis of chronic migraine headache been established using the International Classification of Headache Disorders, Third Edition? Has there been a persistent three month history of recurring debilitating headache documented by the member via headache diary or calendar? Are headaches caused by medication rebound or lifestyle issues? Has the member tried and failed adequate trials of prophylactic therapy from at least two different therapy classes (ex: antiseizure, beta blocker, tricyclic antidepressant)?

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

Please fax this completed form to Highmark at 1-833-619-5745

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 NOSince 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** hyperhidrosis? YES NOPlease 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 NOHave 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 verify member's eligibility and benefits through the health plan****

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