



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: _____

[] Buy & Bill [] Drug Supplied by Specialty Pharmacy (Pharmacy Name: _____ NPI: _____)

Form with checkboxes for BOTOX (J0585), DYSPORT (J0586), MYBLOC (J0587), XEOMIN (J0588), and OTHER (J_____). Includes fields for Dose or number of units, Frequency, and 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 recurring 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

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**Please attach all pertinent clinical information****FOR HYPERHIDROSIS**Does the member have **severe** hyperidrosis? 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**Attached:** YES NO****Please verify member's eligibility and benefits through the health plan****

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