Botulinum Toxin (Medical Policy II-16)
Commercial Pre-Authorization (PA) Request Form

Please review the medical policy review criteria on **providers.bluecrossmn.com** prior to submission.

Effective May 1, 2019, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) providers are required to use the Availity® Provider Portal to submit preservice prior authorization requests. **Faxes and phone calls for these requests will no longer be accepted by Blue Cross**. Please complete the clinical sections on this form and attach it to your request at **Availity.com** to ensure a timely review.

Providers outside of Minnesota without electronic access can fax this form, along with clinical records to support the request, to (651) 662-2810.

Patient Information

☐ **Request for Urgent Review:** By checking this box, I certify that applying the standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function per Federal definition of "Urgent".

Member ID: _____ Group number: _____

Member name: _____ Date of birth (mm/dd/yy): _____

Member address: _____

Member city/state/zip: _____

Member phone: _____-_____-_____

Servicing Provider Information

Contact person: _____ Phone: _____-_____-_____

Servicing provider name: _____

Servicing provider ID/NPI number: _____

Servicing provider address: _____

City/state/zip: _____

Servicing provider phone: _____-_____-_____ Servicing provider fax: _____-_____-_____

Inpatient/Outpatient Facility name: _____ Facility ID: _____

Ordering Provider Info

Ordering provider name: _____

Ordering provider ID/NPI number: _____

Ordering provider address: _____

City/state/zip: _____

Ordering provider phone: _____-_____-_____ Ordering provider fax: _____-_____-_____

Services/Procedures/Items Requested

Please attach all relevant clinical documentation that supports information selected in the form. Checking the boxes without submitting clinical documentation that supports the selection, may result in a denial of the PA request.

Note: Requested Dose/Frequency AND Initial OR Renewal Sections must be completed.

HCPC/CPT Procedure Code(s)	ICD-10 Diagnosis Code(s)	Drug Administration

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			Is Ordering or Servicing Provider above administering the drug? ☐ Yes ☐ No ➔ If no, who will be administering the drug? _____ ➔ Is administering provider doing Buy and Bill? ☐ Yes ☐ No

Services/Procedures/ Items Requested				
	Please select the requested medication(s) and answer the corresponding questions.			
	☐ **Botox**	Requested Dose/Frequency	Start Date (mm/dd/yy)	End Date (mm/dd/yy)
		Is maximum cumulative dose ≤ 400 units every 12 weeks? ☐ Yes ☐ No* Is patient hypersensitive to any component of the Botox formulation? ☐ Yes ☐ No* Does patient have an infection at the injection site? ☐ Yes ☐ No Does patient have a urinary tract infection or urinary retention? ☐ Yes ☐ No		
	☐ **Dysport**	Requested Dose/Frequency	Start Date (mm/dd/yy)	End Date (mm/dd/yy)
		What is the patient's current weight? _____ ☐ KG ☐ LB Is maximum cumulative dose ≤ 1,000 units every 12 weeks? ☐ Yes ☐ No* Is patient hypersensitive to any component of the Dysport formulation? ☐ Yes ☐ No* Does patient have an allergy to cow's milk protein? ☐ Yes ☐ No Does patient have an infection at the injection site? ☐ Yes ☐ No		
	☐ **Myobloc**	Requested Dose/Frequency	Start Date (mm/dd/yy)	End Date (mm/dd/yy)
		Is maximum cumulative dose ≤ 10,000 units every 12 weeks? ☐ Yes ☐ No* Is patient hypersensitive to any component of the Myobloc formulation? ☐ Yes ☐ No* Does the patient have an infection at the injection site? ☐ Yes ☐ No		
	☐ **Xeomin**	Requested Dose/Frequency	Start Date (mm/dd/yy)	End Date (mm/dd/yy)
		Is maximum cumulative dose ≤ 400 units every 12 weeks? ☐ Yes ☐ No* Is patient hypersensitive to any component of the Xeomin formulation? ☐ Yes ☐ No* Does the patient have an infection at the injection site? ☐ Yes ☐ No		

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	Is the requested dose above the maximum treatment dose specified in the medical policy for the indication? ☐ Yes* ☐ No If yes, has the patient's dose been titrated up based on ineffective symptom control at lower doses? ☐ Yes* ☐ No Is the requested dosing interval more frequent than the minimum dosing interval specified in the medical policy for the indication? ☐ Yes* ☐ No If yes, has the patient's dosing interval been shortened based on ineffective symptom control at longer intervals? ☐ Yes* ☐ No ***Please attach all relevant clinical documentation supporting dosing and frequency request**
Initial Request	**Please select the indication(s) and answer the corresponding questions. If applicable, please attach supporting documentation for drug intolerance, contraindications or hypersensitivity**
	☐ **Blepharospasm associated with dystonia, including benign essential blepharospasm or VII (facial) nerve disorders** If requesting Botox or Dysport, is the patient 12 years of age or older? ☐ Yes ☐ No If requesting Xeomin, is the patient 18 years of age or older? ☐ Yes ☐ No
	☐ **Cervical dystonia (spasmodic torticollis; applicable whether congenital, due to child birth injury or traumatic injury)** Does the patient have a sustained head tilt or abnormal posturing with a limited range of motion in the neck? ☐ Yes ☐ No Does the patient have a history of recurrent involuntary contraction of one or more of the muscles of the neck (e.g., sternoicleidomastoid, splenius, trapezius, or posterior cervical muscles)? ☐ Yes ☐ No
	☐ **Chronic anal fissure** Has the patient tried any conventional therapy (e.g., bulking agents, sitz baths, laxatives, dietary changes, or 0.4% intra-anal nitroglycerin)? ☐ Yes ☐ No
	☐ **Chronic migraine headache** **Note: Please provide documentation of clinical evaluation and intolerance to the prerequisite therapy.** Is the patient 18 years of age or older? ☐ Yes ☐ No Has the patient had 15 or more headache days (headaches that last 4 hours or more per day) per month for 3 months or longer, with 50% or more of headaches being migraine/probable migraine? ☐ Yes ☐ No Has the patient been evaluated for and confirmed not to have medication overuse headache? ☐ Yes ☐ No Has the patient tried ONE conventional agent prerequisite from at least TWO different classes? (check all that apply) ☐ Yes ☐ No ☐ Antidepressants (e.g., amitriptyline, venlafaxine) ☐ Antiepileptics (e.g., topiramate, valproic acid) ☐ Calcitonin gene-related peptides (CGRPs) (e.g., erenumab, fremanezumab, galcanezumab) ☐ Calcium channel or beta blockers (e.g., propranolol, metoprolol, bisoprolol, verapamil) ☐ Other: _____

	☐ **Dystonia associated with ONE of the following conditions:** ☐ **Focal upper limb dystonia (e.g., organic writer's cramp)** ☐ **Oromandibular dystonia (e.g., orofacial dyskinesia, jaw-closing dystonia, Meige syndrome)** ☐ **Laryngeal dystonia (adductor spasmodic dysphonia)** ☐ **Idiopathic (primary or genetic) torsion dystonia** ☐ **Symptomatic (acquired) torsion dystonia**
	☐ **Esophageal achalasia** Has the patient tried and not responded to pneumatic dilation or myotomy? ☐ Yes ☐ No Is the patient a candidate for pneumatic dilation of myotomy? ☐ Yes ☐ No
	☐ **Facial synkinesis**
	☐ **Hemifacial spasm**
Initial Request	☐ **Overactive bladder** Does the patient have symptoms of urge urinary incontinence, urgency, and frequency? ☐ Yes ☐ No Has the patient had inadequate response to conservative therapies, including bladder training, pelvic floor muscle exercises, and fluid management? ☐ Yes ☐ No Has the patient tried at least TWO first-line conventional agent prerequisites from TWO different classes? (Check all that apply.) ☐ Yes ☐ No ☐ Anticholinergic agent (e.g., oxybutynin, tolterodine, trospium, darifenacin, solifenacin, or fesoterodine) ☐ Myrbetriq (mirabegron) ☐ Other: _____ Does the patient have a documented intolerance, FDA-labeled contraindication, or hypersensitivity to any of the first-line conventional agent prerequisites? ☐ Yes ☐ No (Check all that apply.) ☐ Anticholinergic agent (e.g., oxybutynin, tolterodine, trospium, darifenacin, solifenacin, or fesoterodine) ☐ Myrbetriq (mirabegron) ☐ Other:_____
	☐ **Palmar or axillary hyperhidrosis** Has the patient tried 20% aluminum chloride solution? ☐ Yes ☐ No Does the patient have a documented intolerance, FDA-labeled contraindications, or hyper-sensitivity to 20% aluminum chloride solution? ☐ Yes ☐ No
	☐ **Sialorrhea** Has the patient tried any conventional agent prerequisites (e.g., oral hyoscine, atropine drops, glycopyrrolate, or amitriptyline)? ☐ Yes ☐ No Does the patient have a documented intolerance, FDA-labeled contraindication, or hyper-sensitivity to any of the conventional agent prerequisities? ☐ Yes ☐ No
	☐ **Spasticity associated with ONE of the following conditions:** ☐ **Cerebral Palsy** ☐ **Spastic hemiplegia** ☐ **Stroke** ☐ **Neuromyelitis optica** ☐ **Acquired spinal cord or traumatic brain injury** ☐ **Multiple sclerosis** ☐ **Hereditary spastic paraplegia** ☐ **Schilder's disease**
	☐ **Spasticity of the lower limb**

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	☐ **Spasticity of the upper limb**
	☐ **Strabismus, including persistent cranial VI nerve palsy of one month or longer** Has the patient had inadequate response to corrective lenses? ☐ Yes ☐ No Has the patient had inadequate response to any other additional corrective therapies? ☐ Yes ☐ No Does the patient have good vision in both eyes? ☐ Yes ☐ No Are the patient's eye movements restricted? ☐ Yes ☐ No Does the patient have a small-to-moderate angle of esotropia? ☐ Yes ☐ No Is it possible for the patient to experience binocular vision? ☐ Yes ☐ No
Initial Request	☐ **Urinary incontinence due to detrusor overactivity associated with a neurologic conditions (e.g., spinal-cord injury, multiple sclerosis)** Has the patient tried at least TWO first-line conventional agent prerequisites from TWO different classes? (check all that apply) ☐ Yes ☐ No ☐ Anticholinergic agent (e.g., oxybutynin, tolterodine, trospium, darifenacin, solifenancin, or fesoterodine) ☐ Myrbetriq (mirabegron) ☐ Other: _____ Does the patient have a documented intolerance, FDA-labeled contraindication, or hyper-sensitivity to any of the first-line conventional agent prerequisites? (check all that apply) ☐ Yes ☐ No ☐ Anticholinergic agent (e.g., oxybutynin, tolterodine, trospium, darifenacine, solifenacine, or fesoterodine) ☐ Mybetriq (mirabegron) ☐ Other: _____
	☐ **Other** (please specify below) **Please provide supporting documentation for the requested medication**
Renewal Request	**Note:** Requested Dose/Frequency AND Patient History Sections must also be completed. Has the patient been previously approved for the requested agent through Blue Cross and Blue Shield of Minnesota's initial review process? ☐ Yes ☐ No Does the patient have an approved diagnosis listed under "Initial Request"? ☐ Yes ☐ No **If the diagnosis is chronic migraine headache:** Has treatment with the requested agent reduced the number of headache days by at least 7 days per month from baseline prior to therapy)?* ☐ Yes ☐ No **If the diagnosis is NOT chronic migraine headache:** Has treatment with the requested agent resulted in a reduction of symptom severity and/or frequency from baseline (prior to therapy)?* ☐ Yes ☐ No ***Please provide supporting documentation.**

Please attach all relevant clinical documentation that supports information selected in the form.

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Description / Additional Information:

Total pages: _____

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