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

BlueCross BlueShield Minnesota

Please refer to current prior authorization lists to verify if service requires prior authorization. Lists are located at https://www.bluecrossmn.com/providers/medical-policy-and-utilization-management

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 Information

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
		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)

If adult patient is maximum cumulative dose ≤ 400 units every 12 weeks? ☐ Yes ☐ No*
If pediatric patient, is maximum cumulative dose the lesser of 10 units/kg or 340 units every 12 weeks? ☐ Yes ☐ No*
Is the patient hypersensitive to any component of the Botox formulation? ☐ Yes ☐ No*
Does patient have an infection at the injection site? ☐ 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

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 cranial nerve VII (facial)-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 childbirth 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

Initial Request

☐ **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 per month for 3 months or longer, AND 8 or more migraine days per month for at least 3 months? ☐ 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 Of the following classes? (check all that apply) ☐ Yes ☐ No

- ☐ Antidepressants (e.g., amitriptyline, venlafaxine)
- ☐ Anticonvulsants (e.g., topiramate, valproic acid)
- ☐ Self-administered Calcitonin gene-related peptides (CGRPs) (i.e., erenumab [Aimovig], galcanezumab) [Emgality]
- ☐ Calcium channel or beta blockers (e.g., propranolol, metoprolol, bisoprolol, verapamil)
- ☐ Other: _____

Has the drug been prescribed by or in consultation with a headache specialist (e.g., neurologist, pain management specialist, or specialist with United Council or Neurologic Subspecialties)? ☐ Yes ☐ No

Is the drug to be used for migraine prophylaxis? ☐ Yes ☐ No

Not to be used in combination with a CGRP agent for migraine prophylaxis? ☐ Yes ☐ No

☐ **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 spastic 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**

☐ **Neurogenic detrusor overactivity**

Is the patient 5 years of age or older? ☐ 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)
- ☐ 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)
- ☐ Mybetriq (mirabegron)
- ☐ Other: _____

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**
- ☐ **Stroke**
- ☐ **Acquired spinal cord or traumatic brain injury**
- ☐ **Hereditary spastic paraplegia**
- ☐ **Spastic hemiplegia**
- ☐ **Neuromyelitis optica**
- ☐ **Multiple sclerosis**
- ☐ **Schilder's disease**

☐ **Spasticity of the lower limb**

☐ **Spasticity of the upper limb**

☐ **Strabismus, including persistent cranial nerve VI 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

☐ **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: _____

Initial Request

☐ **Other** (please specify below)

Please provide supporting documentation for the requested medication

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 or migraine days per month by at least 50% 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.

Renewal Request	

Description / Additional Information:

Total pages: _____