Independence

Today's date: _____ **Date medication needed:** _____

Prior Authorization Form - Botulinum Toxins

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Select one: ☐ **Botox®** ☐ **Dysport®** ☐ **Myobloc®** ☐ **Xeomin®** **Check one:** ☐ New start ☐ Continued treatment

Number of units to be injected _____

Patient information (please print)		**Physician information (please print)**	
Patient name		Prescribing physician	
Address		Office address	
City, state, ZIP		City, state, ZIP	
Patient telephone #		Office contact	
Patient ID		Office telephone #	
Date of Birth	Weight	Fax #	NPI

☐ **No delivery requested; physician will use office supply. Authorization only.**

☐ **Delivery requested to the physician's office.**

**** A copy of the prescription must accompany the medication request for delivery.****

1) Diagnosis for drug requested (must include ICD-10): _____

2) Patient medical information

For hyperhidrosis only:

a. Is the age of onset of hyperhidrosis younger than 25 years of age? ☐ Yes ☐ No
b. Is focal sweating bilateral and relatively symmetric? ☐ Yes ☐ No
c. Does the patient sweat during sleep? ☐ Yes ☐ No
d. Does the patient have a positive family history of severe primary focal hyperhidrosis? ☐ Yes ☐ No
e. Does the hyperhidrosis significantly impair the patient's participation in daily activities? ☐ Yes ☐ No
f. Does the patient have underlying disease causing hyperhidrosis? If yes, specify: _____ ☐ Yes ☐ No
g. Which area will be treated? (e.g., palmar, plantar, axillary) _____
h. How many units will be injected into each area? _____

For chronic migraine or probable chronic migraine only:

a. Has a neurologist established the diagnosis of chronic migraine headache? ☐ Yes ☐ No
b. Have the migraines occurred at least 15 days per month for at least 3 months? ☐ Yes ☐ No
c. Does the migraine last at least 4 hours per day? ☐ Yes ☐ No
d. Does the patient have either nausea or sensitivity to light and/or sound with the migraine? ☐ Yes ☐ No
e. How does the patient describe the pain associated with the migraine? (Select all that apply)
   - ☐ Moderate-to-severe pain intensity
   - ☐ Unilateral pain
   - ☐ Pain aggravated by movement or that prohibits movement
   - ☐ Throbbing pain
f. Has the patient failed to respond to a 4-week course of at least two agents from the different drug classes listed below? If yes, list the drug(s) and the duration(s) below: ☐ Yes ☐ No
   1. Tricyclic antidepressants; (list drug[s]/duration[s]) _____
   2. Serotonin-norepinephrine reuptake inhibitors; (list drug[s]/duration[s]) _____
   3. Selective serotonin reuptake inhibitors; (list drug[s]/duration[s]) _____
   4. Anticonvulsants; (list drug[s]/duration[s]) _____
   5. Beta-blockers; (list drug[s]/duration[s]) _____
   6. Calcium channel blockers; (list drug[s]/duration[s]) _____
   7. Other drug(s); (list drug[s]/duration[s]) _____

3) Prescription Information:

Dosage _____ Frequency _____ Refill x _____ month(s)

Physician's Signature: _____

Please fax this completed form to 215-761-9580.