



**Independence
Blue Cross**

**Prior Authorization Form
Botulinum Toxins (Type A & B)**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Botox® 100 U vial Myobloc® 2500 U (0.5ml vial) 5000 U (1ml vial) 10,000 U (2ml vial)

Quantity _____ Refill x _____ months

Instructions _____

Physician's signature _____ Provider NPI: _____ MD# _____

Date: _____ Date medication needed _____

Patient Information

Patient's name _____
Patient's address _____
City, State, Zip: _____
Patient's phone # _____
Patient's ID#: _____ DOB _____

Prescriber Information

Prescribing physician _____
Office address _____
City, State, Zip: _____
Office contact _____
Office # _____ Fax# _____

Upon approval, delivery is available. Complete section below.

<input type="checkbox"/> No Delivery Requested	<input type="checkbox"/> Delivery Requested
<input type="checkbox"/> Physician Supply, authorization only [Flex series]	<input type="checkbox"/> Physician's office <input type="checkbox"/> Patient's home
<input type="checkbox"/> Member Pick up at pharmacy if benefit available	Preferred Vendor: _____

****A copy of the prescription must accompany the medication request****

Primary Diagnosis:

- | | |
|--|---|
| <input type="checkbox"/> 333.81 Blepharospasm | <input type="checkbox"/> 378.00 Strabismus |
| <input type="checkbox"/> 333.83 Cervical Dystonia | <input type="checkbox"/> 728.85 Spasm of the muscle (secondary diagnosis req'd) |
| <input type="checkbox"/> 351.9 Facial nerve disorder | |
| <input type="checkbox"/> 351.8 Hemifacial spasm | <input type="checkbox"/> 343.0 Infantile cerebral palsy |
| <input type="checkbox"/> 350.8 Frey's syndrome | <input type="checkbox"/> 333.6 Focal and segmental limb dystonias |
| <input type="checkbox"/> 596.8 Anismus | <input type="checkbox"/> Hyperhydrosis (specify ICD-9 code) _____ |

Other diagnosis not listed above. This field is required for review of the request. (Please indicate ICD-9 code, description plus previous therapies). If the information exceeds the space below, please attach a letter of medical necessity.

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (215) 761-9165 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only	Vendor _____	Billing Code _____	M / Rx
Document # _____	LOB _____	Processor Initials _____	
M F Rx coverage Y N	STANDARD - SELECT	Date _____	
Previous Auth Y N	Auth# _____	From _____ To _____	
Approved Reviewer Initials _____	Date _____	Coverage effective date / /	