



**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	<input type="checkbox"/> Physician's office <input type="checkbox"/> Patient's home
<input type="checkbox"/> Member Pick up at pharmacy if benefit available	

****If delivery is requested, please attach a copy of the RX in order to expedite the process****

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"/> 351.8 Hemifacial spasm | _____ |
| <input type="checkbox"/> 343.0 Infantile cerebral palsy | <input type="checkbox"/> 333.6 Focal and segmental limb dystonias |
| <input type="checkbox"/> Hyperhydrosis(specify ICD9 code): _____ | <input type="checkbox"/> Other ICD9: _____ |

Please answer the questions below for the requests of the diagnosis of Hyperhydrosis

- | | |
|---|--|
| a. Is the age of onset of Hyperhydrosis 25 years or less? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Is focal sweating bilateral and relatively symmetric? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Does the patient sweat during sleep? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Does the patient have a positive family history of severe primary focal hyperhydrosis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Does the hyperhydrosis significantly impair patient's participation in the daily activities? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Does the patient have any underlying disease, if Yes please specify _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Please add any other supporting medical information that maybe useful in the decision making:

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 / /	