



Botox®, Dysport®, Myobloc®, Xeomin® (botulinum toxin)
Prior Authorization Form
Complete Patient and Physician Information (PLEASE PRINT)

Step 1:			
Patient Name:	Physician Name:		
Address:	Address:		
Member ID:	NPI#:		
Member DOB:	Phone #:		
Service Provider	Person completing form:		
Pharmacy Name:	Fax #:		
Pharmacy Phone:	Date of Service:		
Step 2:			
Complete the Clinical Assessment			
Diagnosis (please check one)	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none; vertical-align: top;"> <ul style="list-style-type: none"> ▪ For Botox® (onabotulinumtoxinA): <input type="checkbox"/> Blepharospasm associated with dystonia in patients > 12 years old <input type="checkbox"/> Strabismus <input type="checkbox"/> Cervical Dystonia <input type="checkbox"/> Severe primary hyperhidrosis unresponsive to topical agents; either axillary, palmar, or plantar (<i>Circle one</i>) <input type="checkbox"/> Upper limb spasticity in adults, (<i>Please state underlying diagnosis:</i>) _____ <input type="checkbox"/> Prophylaxis of headache in adult patients with chronic migraine (≥ 15 headache days per month with headache lasting at least 4 hours) unresponsive to a 60 day trial of at least 2 different classes of prophylactic medications <input type="checkbox"/> Other: _____ </td> <td style="width: 50%; border: none; vertical-align: top;"> <ul style="list-style-type: none"> ▪ For Dysport® (abobotulinumtoxinA): <input type="checkbox"/> Cervical Dystonia <input type="checkbox"/> Other: _____ ▪ For Myobloc® (rimabotulinumtoxinB): <input type="checkbox"/> Cervical Dystonia <input type="checkbox"/> Other: _____ ▪ For Xeomin® (incobotulinumtoxinA): <input type="checkbox"/> Blepharospasm in adults who were previously treated with Botox® (onabotulinumtoxinA) <input type="checkbox"/> Cervical Dystonia <input type="checkbox"/> Other: _____ </td> </tr> </table>	<ul style="list-style-type: none"> ▪ For Botox® (onabotulinumtoxinA): <input type="checkbox"/> Blepharospasm associated with dystonia in patients > 12 years old <input type="checkbox"/> Strabismus <input type="checkbox"/> Cervical Dystonia <input type="checkbox"/> Severe primary hyperhidrosis unresponsive to topical agents; either axillary, palmar, or plantar (<i>Circle one</i>) <input type="checkbox"/> Upper limb spasticity in adults, (<i>Please state underlying diagnosis:</i>) _____ <input type="checkbox"/> Prophylaxis of headache in adult patients with chronic migraine (≥ 15 headache days per month with headache lasting at least 4 hours) unresponsive to a 60 day trial of at least 2 different classes of prophylactic medications <input type="checkbox"/> Other: _____ 	<ul style="list-style-type: none"> ▪ For Dysport® (abobotulinumtoxinA): <input type="checkbox"/> Cervical Dystonia <input type="checkbox"/> Other: _____ ▪ For Myobloc® (rimabotulinumtoxinB): <input type="checkbox"/> Cervical Dystonia <input type="checkbox"/> Other: _____ ▪ For Xeomin® (incobotulinumtoxinA): <input type="checkbox"/> Blepharospasm in adults who were previously treated with Botox® (onabotulinumtoxinA) <input type="checkbox"/> Cervical Dystonia <input type="checkbox"/> Other: _____
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	ICD-9 Code:		
Clinical Consideration	The four available botulinum toxin products have different FDA-approved indications. Botulinum toxin is also used for many off-label indications. Our Care Management Team will determine whether 'other' indications are consistent with a medically necessary course of therapy. Cosmetic indications will not be considered medically necessary.		
CAUTION:	Although similar in certain aspects, botulinum toxins are NOT interchangeable. They are chemically, pharmacologically, and clinically distinct. There is no established method to convert dosing with one neurotoxin to appropriate dosing with another neurotoxin. Please be vigilant when choosing the appropriate dose of a particular botulinum toxin.		
Supporting Documentation	HCPSC Code: Please attach a copy of the clinical notes AND complete ALL of the information below: <input type="checkbox"/> Botox® or <input type="checkbox"/> Dysport® or <input type="checkbox"/> Myobloc® or <input type="checkbox"/> Xeomin® _____ Estimated # of Units to administered <input type="checkbox"/> Inpatient stay <input type="checkbox"/> Observation stay <input type="checkbox"/> Outpatient services <input type="checkbox"/> Office <input type="checkbox"/> Home		
Step 3			
Fax completed form to			
Rocky Mountain Health Plans: 877-201-7302 or 970-254-5738			
The preauthorization for services noted in this form is only for the time period during which the patient remains eligible on the patient's current health benefit plan or for a shorter period as specified in this form. Rocky Mountain Health Plans is not financially responsible for the services that are preauthorized if the patient is not eligible at the date services are provided. Further as permitted by applicable law, this preauthorization is subject to concurrent review as to medical necessity, appropriateness of efficacy and coverage for services being provided and is subject to the terms and conditions in the member's health benefit contract, including but not limited to coordination of benefits, provisions, preexisting conditions and limitations, and any agreements between Rocky Mountain Health Plans and the health care provider. Billing for the services preauthorized on this form is subject to nationally standardized rules for coding and paying health services as used by Rocky Mountain Health Plans.			

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