

Botulinum Toxin Prior Authorization Form

Physician Providers please note ** below

****Physician Providers from Office supply (J-Code Billing) – Fax request to: ACS @ 1-907-644-8131**

^ Procedure codes, Date of Service, and ICD-9 fields are required fields for physician providers.

Pharmacy Providers - (Drug to be dispensed from Pharmacy) Fax request to: (888) 603-7696 Phone 1-800-331-4475

Incomplete requests will be denied until all required information is received.

Note: This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form.

Form available: <http://www.hss.state.ak.us/dhcs/pharmacy/medpriorauthoriz.htm>

Revised 10-2011

REQUESTOR	Requestor Name (<i>Print</i>)		Title																					
RECIPIENT	Last Name, First Name, Middle I.:																							
DOB:	Recipient ID:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female																						
PRESCRIBER	Name:		NPI: - - - - -																					
	Phone: ()	Fax: ()																						
	Specialty:	Proc Code^	DOS^:																					
PHARMACY	Name:		NPI: - - - - -																					
	Phone: ()	Fax: ()																						
REQUEST	Drug:	Strength:	Dosage Form																					
Primary Diagnosis		ICD-9 CM^:	Dosage schedule:																					
Other Diagnoses:			QTY	Day Supply:																				
RATIONALE FOR PRIOR AUTHORIZATION			Prior Authorization start date:																					
<p>1. How old is the patient?</p> <p style="text-align: center;"> <input type="checkbox"/> <12 years old <input type="checkbox"/> 12-17 years old <input type="checkbox"/> ≥ 18 years old </p>																								
<p>2. The patient is being treated for which of the following:</p> <table style="width:100%; border: none;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>A. Cervical Dystonia</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> <tr> <td>B. Upper Limb Spasticity</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> <tr> <td>C. Strabismus</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> <tr> <td>D. Severe Axillary Hyperhidrosis</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> <tr> <td>E. Blephrospasm</td> <td style="text-align: center;">[] <i>Answer question 3 below</i></td> <td style="text-align: center;">[]</td> </tr> <tr> <td>F. Chronic Migraines</td> <td style="text-align: center;">[] <i>Answer question 4 below</i></td> <td style="text-align: center;">[]</td> </tr> </table>					YES	NO	A. Cervical Dystonia	[]	[]	B. Upper Limb Spasticity	[]	[]	C. Strabismus	[]	[]	D. Severe Axillary Hyperhidrosis	[]	[]	E. Blephrospasm	[] <i>Answer question 3 below</i>	[]	F. Chronic Migraines	[] <i>Answer question 4 below</i>	[]
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<p>3. If the patient is being treated for blephrospasm please answer the following:</p> <table style="width:100%; border: none;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>A. Is the patient unable to open their eyelid(s) or functionally blind due to dystonia?</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> <tr> <td>B. Are you the ordering neurologist or ophthalmologist?</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> </table> <p style="margin-left: 40px;"><i>If NO, please submit the plan or chart notes from the ordering neurologist or ophthalmologist with this request.</i></p>					YES	NO	A. Is the patient unable to open their eyelid(s) or functionally blind due to dystonia?	[]	[]	B. Are you the ordering neurologist or ophthalmologist?	[]	[]												
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<p>4. If the patient is being treated for chronic migraines please answer the following:</p> <table style="width:100%; border: none;"> <tr> <td></td> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> <tr> <td>A. Does the patient have headaches ≥ 15 days per month?</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> <tr> <td>B. Is the patient on a medication regimen for migraine prophylaxis?</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> </table> <p style="margin-left: 40px;"><i>If YES, please list the regimen: _____</i></p> <table style="width:100%; border: none;"> <tr> <td>C. Are you the ordering neurologist?</td> <td style="text-align: center;">[]</td> <td style="text-align: center;">[]</td> </tr> </table> <p style="margin-left: 40px;"><i>If NO, please submit the plan of care or chart notes from the ordering neurologist.</i></p>					YES	NO	A. Does the patient have headaches ≥ 15 days per month?	[]	[]	B. Is the patient on a medication regimen for migraine prophylaxis?	[]	[]	C. Are you the ordering neurologist?	[]	[]									
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<p>Prescriber's Signature: _____</p>			<p>Date: _____</p>																					

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