Health Partners Plans

HEALTH PARTNERS PLANS
Phone 215-991-4300 Fax 1-866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

BOTULINUM TOXINS PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

Prior authorization guidelines for **Botulinum Toxins** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html.

☐New request ☐Renewal request	Total # of pages ______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Units/package size:	Total quantity requested per treatment:
Injection site(s) & dose per site:		
Diagnosis (*submit documentation*):		Dx code (*required*):
Dates of previous administration and injection sites (*submit documentation*):		

Complete all sections that apply to the beneficiary and this request.

Check all that apply and SUBMIT DOCUMENTATION for each item.

INITIAL requests

☐**For a NON-PREFERRED Botulinum Toxin:**

- ☐Has a history of trial and failure of or a contraindication or an intolerance to the preferred Botulinum Toxins that are approved or medically accepted for treatment of the beneficiary's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

☐**For a diagnosis of CHRONIC SPASTICITY:**

- ☐Has spasticity that interferes with activities of daily living
- ☐Has spasticity that is expected to result in joint contracture with future growth
- ☐If the beneficiary has contractures, has been considered for surgical intervention
- ☐One of the following:
  - ☐Has focal spasticity
  - ☐Is under 18 years of age
  - ☐Is 18 years of age or older and tried and failed or has a contraindication or an intolerance to an oral medication for spasticity
- ☐Botulinum Toxin is prescribed to enhance function or allow for additional therapeutic modalities to be used

- ☐ Will use the requested botulinum toxin in conjunction with other appropriate therapeutic modalities (e.g., PT, OT, gradual splinting, etc.)

☐ **For a diagnosis of AXILLARY HYPERHIDROSIS:**

- ☐ Tried and failed or has a contraindication or an intolerance to a topical agent such as aluminum chloride 20% solution

☐ **For a diagnosis of CHRONIC MIGRAINE HEADACHE:**

- ☐ Has a diagnosis of migraine headache consistent with the current International Headache Society Classification of Headache Disorders
- ☐ Migraine headache is not attributable to other causes, such as medication overuse
- ☐ Is prescribed the Botulinum Toxin by or in consultation with a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties or a neurologist
- ☐ Tried and failed or has a contraindication or an intolerance to at least one drug used for migraine prevention from at least 2 of the following classes:
    - ☐ Anticonvulsants (e.g., divalproex, topiramate, valproic acid)
    - ☐ Antidepressants (e.g., amitriptyline, venlafaxine)
    - ☐ Beta blockers (e.g., metoprolol, propranolol, timolol)
    - ☐ CGRP-targeting migraine preventive therapies (e.g., gepants, monoclonal antibodies)

☐ **For a diagnosis of URINARY INCONTINENCE due to detrusor overactivity:**

- ☐ Has an associated neurologic condition
- ☐ Tried and failed or has a contraindication or an intolerance to an anticholinergic drug used for the treatment of urinary incontinence (e.g., darifenacin, fesoterodine, oxybutynin, solifenacin, tolterodine, trospium)

☐ **For a diagnosis of OVERACTIVE BLADDER:**

- ☐ Has symptoms of urge urinary incontinence, urgency, and frequency
- ☐ Tried and failed or has a contraindication or an intolerance to at least 2 drugs used for the treatment of overactive bladder (e.g., anticholinergics, beta-3 adrenergic agonists)

RENEWAL requests

☐ Experienced a positive clinical response to the Botulinum Toxin

☐ One of the following:

- ☐ For the treatment of chronic migraine headache, requires repeat injection to reduce the frequency, severity, or duration of symptoms
- ☐ For the treatment of all other diagnoses, has symptoms that returned to such a degree that repeat injection with Botulinum Toxin is required

☐ The frequency of injection of Botulinum Toxin exceeds the FDA-approved package labeling

- ☐ The previous treatment was well-tolerated but inadequate
- ☐ The requested dose and increased frequency of injection of Botulinum Toxin are supported by medical literature as safe and effective for the diagnosis

☐ **For a diagnosis of CHRONIC MIGRAINE HEADACHE:**

- ☐ Is prescribed the Botulinum Toxin by or in consultation with a headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties or a neurologist

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 866-240-3712

Prescriber Signature:	**Date**: