Today's Date: _____
Date medication needed: _____

AmeriHealth

Prior Authorization Form Botulinum Toxins

ONLY COMPLETED REQUESTS WILL BE REVIEWED

☐ **Botox® 100u vial** ☐ **Dysport® 500u vial** ☐ **Xeomin® (indicate vial size: ❍ 50u ❍ 100u)**
☐ **Myobloc® (indicate vial size: ❍ 2500u [0.5ml vial] ❍ 5000u [1ml vial] ❍ 10,000u [2ml vial])**

Patient Information (please print)

Patient's Name:_____
Address:_____
City/State/Zip Code:_____
Patient ID#:_____
DOB: _____Weight:_____Height:_____

Provider Information (please print)

Prescribing Physician:_____
Office Address:_____
City/State/Zip code:_____
Office Telephone/Contact:_____
Office Fax:_____NPI:_____

Upon approval, delivery is available by completing the section below.

☐ **N/A – No delivery requested, authorization only - physician will use office supply**

☐ **Delivery requested (indicate where medication should be delivered: ❍ Physician's office ❍ Patient's home)**

****A copy of the prescription must accompany the medication request for delivery.****

1. **Physician specialty (required; specify all specialties)** _____

2. **Diagnosis for drug requested (must include ICD-9):**

☐ 333.6 Focal/segmental limb dystonias ☐ 333.81 Blepharospasm ☐ 333.83 Cervical dystonia
☐ 343.0 Infantile cerebral palsy ☐ 351.8 Hemifacial spasm ☐ 378.00 Strabismus
☐ 728.85 Spasm of the muscle (secondary diagnosis required) ☐ Other (specify ICD-9) _____

3. **Patient medical information:**

For hyperhidrosis:

a. Is the age of onset of hyperhidrosis 25 years or less?	☐ Yes	☐ No
b. Is focal sweating bilateral and relatively symmetric?	☐ Yes	☐ No
c. Does the patient sweat during sleep?	☐ Yes	☐ No
d. Does the patient have a positive family history of severe primary focal hyperhidrosis?	☐ Yes	☐ No
e. Does the hyperhidrosis significantly impair the patient's participation in daily activities?	☐ Yes	☐ No
f. Does the patient have any underlying disease? If yes please specify _____	☐ Yes	☐ No

For migraine or probable migraine:

a. Is the frequency of migraine ≥ 15 days per month?	☐ Yes	☐ No
b. Does the headache last ≥ 4 hours per day?	☐ Yes	☐ No

4. **Patient history (please list any previous or current therapies related to the diagnosis):**

Drug name	Dates	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

_____

_____

5. **Prescription information:**

Quantity _____ Refill x _____month(s)
Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)
Physician's signature _____

Fax completed form to 215-761-9165. Your office will receive a response by fax within two business days.