Alaska Medicaid

Botox® Prior Authorization Form

This form may also be used for requests to exceed the maximum allowed units.

Form available on Alaska Medicaid's Medication Prior Authorization website

Physician providers from office supply (J-Code billing): fax this form to HMS at **(907) 644-8131**. Procedure codes, date of service, and ICD-10 fields are required for physician providers.

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

Request Date: ________________

REQUESTOR INFORMATION

Requestor Name: ________________________________ Title: ________________________

MEMBER INFORMATION

Last Name: ____

First Name: ____

Member ID: ___________________________ Date of Birth: ___________________________

Sex: ☐ Male ☐ Female Member Phone: _________________________

PRESCRIBER INFORMATION

Last Name: ____

First Name: ____

Prescriber NPI: ________________________ Specialty: ______________________________

Prescriber Phone: ______________________ Prescriber Fax: __________________________

Group ID: ____________________________

PHARMACY INFORMATION

Pharmacy Name: ___________________________ Pharmacy NPI: ______________________

Pharmacy Phone: _______________________ Pharmacy Fax: __________________________

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Member's Name (Last, First): ______________________________

DRUG INFORMATION

Drug Name: ______________________________ NDC: ____________________

Drug Strength: ____________________ Dosage Form: ____________________

Dosage Schedule: ____________________ Quantity: __________ Day Supply: __________

Procedure Code: ____________________ Date of Service: ____________________

Is this a physician-administered drug? ☐ Yes ☐ No

CLINICAL CRITERIA

General Questions — Complete the following:

1. Primary diagnosis: ______________________________
2. ICD-10 Code: ______________________________
3. How old is the member?
   - ☐ 2–4 years of age
   - ☐ 5–11 years of age
   - ☐ 12–17 years of age
   - ☐ ≥ 18 years of age
4. The member is being treated for which of the following?
   - ☐ Axillary Hyperhidrosis, Severe
   - ☐ Blepharospasm associated with Dystonia
   - ☐ Cervical Dystonia
   - ☐ Chronic Migraine Prophylaxis
   - ☐ Chronic Sialorrhea
   - ☐ Urinary Incontinence Secondary to Detrusor Overactivity (neurogenic)
   - ☐ Overactive Bladder (non-neurogenic)
   - ☐ Spasticity
   - ☐ Spasticity, Upper Limb
   - ☐ Strabismus
   - ☐ Neurogenic Detrusor Overactivity (NDO)
   - ☐ Other: ______________________________

Note: If this is a non-FDA-approved indication (non-cosmetic), medical literature and a letter of medical necessity (listing previous therapies and diagnosis) must be included with this form.

Member's Name (Last, First): ____________________

CRITERIA (CONTINUED)

Note: Complete sections only as they related to specific diagnosis of the patient

For Axillary Hyperhidrosis:

5. Are topical agents controlling the condition?

   ☐ Yes ☐ No

6. Is the Hyperhidrosis Disease Severity Scale score > 3?

   ☐ Yes ☐ No

For Blepharospasm:

7. Is the member unable to open eyelid(s) or functionally blind due to dystonia?

   ☐ Yes ☐ No

8. Are you the ordering neurologist or ophthalmologist?

   ☐ Yes ☐ No

   If **No**, submit the plan of care and chart notes from the ordering MD.

For Cervical Dystonia:

9. Is the purpose of the treatment to reduce the severity of abnormal head position and neck pain?

   ☐ Yes ☐ No

For Chronic Migraines:

10. Does the patient have headaches ≥ 15 days per month (lasting 4 hours a day or longer)?

    ☐ Yes ☐ No

11. Has the patient tried and had an inadequate response, intolerance, or contraindication to at least 2 migraine prophylaxis classes (e.g., anticonvulsants, beta blockers)?

    ☐ Yes ☐ No

12. Are you the ordering neurologist?

    ☐ Yes ☐ No

    If **No**, submit the plan of care and chart notes from the ordering MD.

For Renewal Authorization — Chronic Migraines Only:

13. Has the headache frequency decreased by at least 2 headache days from baseline in the previous month?

    ☐ Yes ☐ No

CRITERIA (CONTINUED)

For Chronic Sialorrhea:

14. Has the patient tried and failed one first line agent (benztropine, oral hyoscyamine, or glycopyrrolate) or do they have a contradiction to all of them?

☐ Yes ☐ No

For Neurogenic Detrusor Overactivity:

15. Are there documented symptoms of detrusor overactivity?

☐ Yes ☐ No

16. Has the patient tried 2 different pharmacologic treatments for at least 60 days with documentation of inadequate response or a justifiable contradiction to oral antimuscarinics or oral β3- adrenergic receptor agonists (e.g., oxybutynin, tolterodine, or mirabegron)?

☐ Yes ☐ No

For Overactive Bladder:

17. Does the patient have documented moderate to severe symptoms of urge urinary incontinence, urgency, and frequency?

☐ Yes ☐ No

18. Has the patient had documented behavioral therapy trials?

☐ Yes ☐ No

19. Has the patient tried 2 different pharmacologic treatments for at least 60 days with documentation of inadequate response or a justifiable contradiction to oral antimuscarinics or oral β3- adrenergic receptor agonists (e.g., oxybutynin, tolterodine, or mirabegron)?

☐ Yes ☐ No

For Spasticity:

20. Is the spasticity refractory to oral medication?

☐ Yes ☐ No

For Spasticity of Upper Limb:

21. Is the spasticity secondary to cerebral palsy?

☐ Yes ☐ No

22. Is the spasticity refractory to oral medication?

☐ Yes ☐ No

For Urinary Incontinence Secondary to Detrusor Overactivity:

23. Are there documented symptoms of detrusor overactivity?

☐ Yes ☐ No

Member's Name (Last, First): ______________________________

CRITERIA (CONTINUED)

24. Has the patient tried 2 different pharmacologic treatments for at least 60 days with documentation of inadequate response or a justifiable contradiction to oral antimuscarinics or oral β3- adrenergic receptor agonists (e.g., oxybutynin, tolterodine, or mirabegron)?

☐ Yes ☐ No

☐ Attachments

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Alaska Medicaid.

Prescriber Signature: ______________________________ **Date:** ______________

(*Required*)

Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: (800) 331-4475

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Pharmacy providers (drug to be dispensed from pharmacy): fax this form to

(888) 603-7696. Incomplete requests will be denied until all required information is received.

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