UnitedHealthcare Community Plan

NC Pharmacy Prior Approval Request for
Neuromuscular Blocking Agents: Botox/Myobloc/Dysport/Xeomin

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____ Provider Fax #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

1. What is the prescribed dosage? _____ units per _____ days
2. What is the diagnosis or indication for the medication?

☐ Blepharospasm **(Botox, Dysport, Xeomin)**
☐ Disorders of eye movement (strabismus) (**Botox)**
☐ Spasmodic torticollis, secondary to cervical dystonia **(Botox, Dysport, Myobloc, Xeomin)**
☐ Spasticity in beneficiaries age 2 and up (**Botox)**
☐ Severe axillary hyperhidrosis (ANSWER QUESTIONS 2 AND 3 BELOW) (**Botox, Dysport)**
☐ Sialorrhea **(Botox, Myobloc)**
☐ Chronic Sialorrhea in beneficiaries age 2 and up **(Xeomin)**
☐ Chronic anal fissure refractory to conservative treatment **(Botox)**
☐ Esophageal achalasia recipients in whom surgical treatment is not indicated **(Botox)**
☐ Infantile cerebral palsy, specified or unspecified **(Botox)**
☐ Hemifacial Spasms **(Botox, Dysport)**
☐ Laryngeal dystonia and adductor spasmodic dysphonia **(Botox)**
☐ Upper limb spasticity in adults **(Dysport, Xeomin**)
☐ Upper limb spasticity in pediatric beneficiaries 2 years of age and older, excluding spasticity caused by cerebral palsy **(Dysport)**
☐ Lower limb spasticity in adults and pediatric beneficiaries 2 years of age and older **(Dysport)**
☐ Upper limb spasticity in pediatric beneficiaries 2 to 17 years of age, excluding spasticity caused by cerebral **(Xeomin)**

2. Does the patient have documented medical complications due to hyperhidrosis? ☐ **Yes** ☐ **No Please List:** _____
3. Has the patient failed a 6-month trial of conservative management including the use of topical aluminum chloride or extra strength antiperspirant?
☐ **Yes** ☐ **No Please List product (s) tried:** _____

Chronic Migraine (18 and older) New Therapy (approval up to 6 months) (BOTOX)

4. Does the patient have 15 or more days each month with headache lasting 4 or more hours? ☐ **Yes** ☐ **No**
5. Has the patient tried and failed prophylactic medications from at least 3 different drug classes (beta blockers, calcium channel Blockers, tricyclic antidepressants and anticonvulsants) each for at least 3 months of therapy? ☐ **Yes** ☐ **No** List meds tried: _____
_____

Chronic Migraine Continuation of Therapy (approval up to 1 year) (BOTOX)

6. Has the patient responded favorably after the first 2 injections? ☐ **Yes** ☐ **No**
7. Has the average number of headache days decreased by 6 or more days from the patient's baseline headache frequency? ☐ **Yes** ☐ **No**

Urinary Incontinence (Botox)

8.. Does the patient have detrusor overactivity associated with neurologic conditions? ☐ **Yes** ☐ **No**
9. Has the patient tried and failed an anticholinergic medication? ☐ **Yes** ☐ **No** List med tried: _____
10. Does the patient have a documented contraindication, intolerable side effects, or allergy to anticholinergic medications? ☐ **Yes** ☐ **No**

Overactive Bladder (BOTOX)

11. Has the beneficiary tried and failed on 2 anticholinergic medications? ☐ **Yes** ☐ **No List meds tried** _____
12. Does the beneficiary have a documented contraindication, intolerable side effect, or allergy to anticholinergic medications? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593