Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

Complete form in its entirety and fax to 1-855-964-0556, Attn. PA pharmacist.

Contact Blue Advantage Medical Management at 1-866-508-7145 if you have questions.

PART B DRUG PRIOR AUTHORIZATION REQUEST FORM

Botulinum Toxins

Request Type:

☐ Standard Review (72 hours)

☐ Expedited Review (24 hours) – By checking this box I certify that applying the 72-hour standard review timeframe might seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

NOTE: Please complete all fields in the form. Missing information and lack of prompt response to requests for additional information may delay response time. Please attach relevant supporting documentation such as labs, results of diagnostic tests and office visit notes to this request.

PATIENT INFORMATION

Patient Name			DOB	
Street Address, City, State, ZIP				
Blue Advantage Member ID#	Sex ☐ M ☐ F	Weight	Height	BMI
Drug Allergies				

PRESCRIBER INFORMATION

Prescriber Name	Office Contact Person and Direct Extension
Street Address, City, State, ZIP	
Office Phone	Office Fax

DRUG DISPENSING AND ADMINISTRATION INFORMATION

Who is furnishing the drug?

- ☐ Physician's office or facility will furnish drug
- ☐ Member picking up drug at a pharmacy
  IMPORTANT NOTE: If member is picking up drug at pharmacy, this request must be faxed to the Part D drug prior authorization department at 1-877-251-5896.

Facility Where Drug is to be Administered

- ☐ Physician's Office
- ☐ Outpatient Infusion Center
  Center Name: _____
- ☐ Home Infusion
  Agency Name: _____
- ☐ Self-inject

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

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MEDICATION

☐ Botox ☐ Dysport ☐ Xeomin ☐ Myobloc Dose, route, frequency: _____ ☐ New start ☐ Continued treatment	Next treatment date:

DIAGNOSIS (select one)

☐ Blepharospasm (Botox, Xeomin) ☐ Cervical dystonia (Botox, Dysport, Myobloc) ☐ Upper limb spasticity (Botox, Dysport, Xeomin) ☐ Chronic migraine prophylaxis (Botox) ☐ Urinary incontinence due to neurologic condition (Botox)	☐ Overactive bladder (Botox) ☐ Achalasia (Botox) ☐ Anal fissure (Botox) ☐ Primary axillary hyperhidrosis (Botox) ☐ Other *(please specify):*

CLINICAL INFORMATION: PLEASE ATTACH SUPPORTING DOCUMENTATION, INCLUDING LABS AND OFFICE VISIT NOTES

Blepharospasm (Botox, Xeomin):

Is blepharospasm associated with dystonia?

☐ Yes ☐ No

For Xeomin request, has the patient had prior treatment with Botox that was inadequate?

☐ Yes ☐ No

Cervical dystonia (Botox, Dysport, Myobloc):

Does the patient have associated neck pain and/or abnormal head position?

☐ Yes ☐ No

Upper limb spasticity (Botox, Dysport, Xeomin):

Check areas of increased muscle tone:

☐ Elbow flexors (biceps)
☐ Wrist flexors (flexor carpi radialis, flexor carpi ulnaris)
☐ Finger flexors (flexor digitorum profundus, flexor digitorum sublimis)

Chronic migraine prophylaxis (Botox):

Number of days per month with headache lasting 4 hours or longer

List prior prophylactic headache treatments that were inadequate

List prior acute headache treatments that were inadequate

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Urinary incontinence due a neurologic condition (Botox):

Neurologic condition

Has the patient tried and had an inadequate response or intolerance to an anticholinergic drug for overactive bladder?

- ☐ Yes *(please list drugs)*
- ☐ No

Overactive bladder (Botox):

Check all symptoms that are present:

- ☐ Urge urinary incontinence
- ☐ Urgency
- ☐ Frequency

Has the patient tried and had an inadequate response or intolerance to an anticholinergic drug for overactive bladder?

- ☐ Yes *(please list drugs)*
- ☐ No

Achalasia (Botox):

Has the patient failed myotomy or dilation?

☐ Yes ☐ No

Is the patient not a candidate for myotomy or dilation (e.g., previous dilation-induced perforation, epiphrenic diverticulum or hiatal hernia that would increase the risk of dilation-induced perforation)?

☐ Yes ☐ No

Primary axillary hyperhidrosis (Botox):

Has the patient tried and failed a topical prescription strength antiperspirant?

☐ Yes ☐ No

Feel free to provide additional information you feel is relevant to the request below:

Prescriber Signature	Date

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