



NC DMA Pharmacy Request for Prior Approval - Botox/Dysport/Myobloc/Xeomin

Recipient Information

DMA-0014 (V.01)

1. Recipient Last Name: _____ 2. First Name: _____
3. Recipient ID #: _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:

8. Prescriber DEA #: _____

Requester Contact Information

Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: Botox Dysport Myobloc Xeomin 10. Strength: _____ 11. Quantity Requested: _____
12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

1. What is the diagnosis or indication for the medication?

Botox, Dysport, Xeomin

- a. Blepharospasm
- b. Disorders of eye movement (strabismus)
- e. Upper limb spasticity in adults
- f. Severe axillary hyperhidrosis (ANSWER QUESTIONS 2 AND 3 BELOW)
- g. Chronic anal fissure refractory to conservative treatment
- h. Esophageal achalasia recipients in whom surgical treatment is not indicated
- i. Spasticity (e.g., from multiple sclerosis, neuromyelitis optica, other demyelinating diseases of the central nervous system, spastic hemiplegia, quadriplegia, hereditary spastic paraplegia, spinal cord injury, traumatic brain injury, and stroke)
- j. Schilder's disease
- m. Infantile cerebral palsy, specified or unspecified
- p. Secondary focal hyperhidrosis (Frey's syndrome)
- r. Laryngeal dystonia and adductor spasmodic dysphonia

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- c. Sialorrhea
- d. Spasmodic torticollis, secondary to cervical dystonia
- k. Congenital diplegia – infantile hemiplegia
- l. Achalasia and Cardiospasm
- n. Hemifacial spasms
- o. Symptomatic (acquired) torsion dystonia
- q. Idiopathic (primary or genetic) torsion dystonia

2. Does the patient have documented medical complications due to hyperhidrosis? Yes No 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
List product (s) tried: _____

Botox only

4a. Chronic Migraine (18 and older)

New Therapy (approval up to 6 months)

- 4b. Does the patient have 15 or more days each month with headache lasting 4 or more hours? Yes No
4c. 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: _____

Continuation of Therapy (approval up to 1 year)

- 4d. Has the patient responded favorably after the first 2 injections? Yes No
4e. Has the average number of headache days decreased by 6 or more days from the patient's baseline headache frequency? Yes No
5a. Urinary Incontinence (Botox)
5b. Does the patient have detrusor overactivity associated with neurologic conditions? Yes No
5c. Has the patient tried and failed an anticholinergic medication? Yes No List med tried: _____
5d. Does the patient have a documented contraindication, intolerable side effects, or allergy to anticholinergic medications? Yes No

Signature of Prescriber: _____ Date: _____

*Prescriber Signature Mandatory

Fax this form to CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505