

**NC Medicaid and NC Health Choice
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 #: _____
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?
Botox, Dysport, Xeomin
 Blepharospasm
 Disorders of eye movement (strabismus)
 Upper limb spasticity in adults
 Severe axillary hyperhidrosis (ANSWER QUESTIONS 2 AND 3 BELOW)
 Chronic anal fissure refractory to conservative treatment
 Esophageal achalasia recipients in whom surgical treatment is not indicated
 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)
 Schilder's disease k. Congenital diplegia – infantile hemiplegia l. Achalasia and Cardiospasm
 Infantile cerebral palsy, specified or unspecified n. Hemifacial spasms o. Symptomatic (acquired) torsion dystonia
 Secondary focal hyperhidrosis (Frey's syndrome) q. Idiopathic (primary or genetic) torsion dystonia
 Laryngeal dystonia and adductor spasmodic dysphonia s. Upper limb spasticity in pediatrics t. Lower limb spasticity in adults
Botox, Dysport, Myobloc, Xeomin
 Sialorrhea
 Spasmodic torticollis, secondary to cervical dystonia

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: _____

Botox only
Chronic Migraine (18 and older) New Therapy (approval up to 6 months):
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)
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

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 CSRA at (855) 710-1969
DHB Pharmacy 63

Pharmacy PA Call Center: (866) 246-8505
02/11/2021