PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Botox/Myobloc/Xeomin/Dysport (NOT MEDICARE)

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please indicate which drug is being requested.

- ☐ Botox
- ☐ Dysport
- ☐ Myobloc
- ☐ Xeomin

Q2. Is the patient a new start to therapy?

☐ Yes ☐ No

Q3. Will Botox, Xeomin, or Myobloc be office-administered using provider stock?

☐ Yes (Botox, Xeomin, and Myobloc do NOT require prior authorization but will still be subject to medical claims edits if office-administered) ☐ No

Q4. Please provide ICD code(s) for diagnosis.

Q5. Please select the applicable diagnosis

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PART OF BAYLOR SCOTT & WHITE HEALTH

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

- ☐ Anal Fissures
- ☐ Axillary hyperhidrosis
- ☐ Blepharospasm
- ☐ Cervical dystonia [spasmodic torticollis]
- ☐ Chronic migraine headache
- ☐ Detrusor and sphincter dyssynergia
- ☐ Essential tremor
- ☐ Hemifacial spasm
- ☐ Neurogenic bladder
- ☐ Non-achalasia esophageal motility disorder [dysphagia]
- ☐ Oculomotor nerve injury
- ☐ Oromandibular dystonia
- ☐ Overactive bladder
- ☐ Pelvic floor dyssynergia [anismus]
- ☐ Sialorrhea associated with neurological disorders
- ☐ Spasmodic and laryngeal dysphonia [including post-laryngectomy]
- ☐ Spasticity [post stroke hemiplegia, upper and lower limb spasticity, cerebral palsy]
- ☐ Strabismus
- ☐ Other (please specify)

Q6. If diagnosis is for anal fissures, please select the following therapies patient has tried for at least two months and failed

- ☐ Topical nitroglycerin
- ☐ Topical nifedipine
- ☐ Other (please specify)

Q7. If request is for Dysport, please select the following therapies to which the patient has tried and failed, has a contraindication, or intolerance.

- ☐ Botox
- ☐ Xeomin
- ☐ Other (please specify)

Q8. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q9. Provide name and NPI of the billing entity

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Q10. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q11. Additional Comments

_____ _____

Prescriber Signature Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.