

Member Name: _____ Member ID: _____ Member DOB: _____
Drug Name: _____ Strength: _____ Directions: _____
Physician Name: _____ Physician Phone #: _____ Specialty: _____
Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Botulinum Toxins – Medical Necessity Request

****Complete pages 1 and 2 for New (Initial) requests ****

General Information

- a. How many units are being prescribed? _____
- b. What parts of the body will the medication be injected into? _____
- c. Has the member received another botulinum toxin within the past 4 months? **Yes or No**

Contraindication Information

- For ALL requests:**
 - a. Does the member have an infection at known injection site? **Yes or No**
- For Botox requests:**
 - a. Does the member have a hypersensitivity to any botulinum toxin product? **Yes or No**
- For Dysport requests:**
 - a. Does the member have an allergy to cow's milk protein? **Yes or No**
 - b. Does the member have a hypersensitivity to any botulinum toxin product? **Yes or No**
- For Myobloc requests:**
 - a. Does the member have a hypersensitivity to any botulinum toxin product? **Yes or No**
- For Xeomin requests:**
 - a. Does the member have hypersensitivity to the active substance botulinum neurotoxin type A? **Yes or No**

Diagnosis Information (please select diagnosis and provide requested information below the diagnosis):

- Cervical Dystonia/Spasmodic Torticollis Upper limb spasticity Lower limb spasticity Hemifacial or Facial Spasm
- Strabismus Dysphagia Focal and segmental limb dystonia or spasm Hyperhidrosis of the palms
- Oromandibular Dystonias
- Frey's syndrome (gustatory sweating, Baillarger's syndrome, Dupuy's syndrome, Auriculotemporal syndrome, Frey-Baillarger syndrome, or Auriculotemporal Syndrome)
- Primary Axillary Hyperhidrosis
 - a. Is the condition severe? **Yes or No**
 - b. Is the condition inadequately managed with a topical agent containing aluminum chloride (e.g., Drysol, Xerac and/or Hypercare 20%)? **Yes or No**
 - c. Does the member have medical complications due to the condition? **Yes or No.**
* If Yes, please describe: _____
 - d. Does the member have a significant impact to activities of daily living due to the condition? **Yes or No**
* If Yes, please describe: _____
- Chronic Migraine
 - a. Is the member managed by a Neurologist? **Yes or No**
 - b. How many headache days per month does the member have? _____
 - c. How many hours per day do the headaches last? _____
 - d. What other medications has the member tried for prevention of migraines (e.g. beta-blockers, anticonvulsants, anti-depressants)?

Physician office's signature _____ **Print Name** _____

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Continued on p. 2

Achalasia

- a. Is the member symptomatic? **Yes or No**
- b. Does the member have a concomitant illness? **Yes or No**
- c. Is the member at high-risk for complications, such as esophageal reflux or perforation? **Yes or No**
- d. Has the member responded to prior myotomy? **Yes or No**
- e. Has the member had esophageal perforation associated with pneumatic dilatation? **Yes or No**
- f. Does the member have epinephrenic diverticulum? **Yes or No**

Post-surgical Head and/or Neck pain

- a. Has the member had neck dissection surgery? **Yes or No**

Overactive Bladder

- a. Does the member have symptoms of urge urinary incontinence, urgency, and frequency? **Yes or No**
- b. Has the member tried an anticholinergic medication?
 - Yes** - List drug name(s) _____
 - No** - If No, why not? _____

Urinary Incontinence due to Neurogenic Detrusor Overactivity

- a. Is it due to a neurologic condition?
 - Yes** - List name of condition: _____
 - No**
- b. Has the member tried an anticholinergic medication? **Yes or No**
If No, why not? _____
- c. Answer the following for Botox requests only:
 - Is Botox being given as an intradetrusor injection? **Yes or No**
 - Does the member have an acute urinary tract infection, urinary retention, or post-void residual urine volume >200ml? **Yes or No**
 - Is the member performing routine clean intermittent self-catherization? **Yes or No**

Spasticity

- a. What medical condition is the spasticity due to? _____
- b. If due to Cerebral Palsy, does the member have dynamic spasticity? **Yes or No**

Sialorrhea (disturbance of salivary gland)

- a. Does the member also have a neurological condition or impairment (e.g., Parkinson's Disease, Amyotrophic Sclerosis (ALS) or Cerebral Palsy)? **Yes or No**

Tourette syndrome

- a. Is the medication being used for treatment of tic and premonitory symptoms? **Yes or No**

Spasmodic Dysphonia (laryngeal dystonia)

- a. Is the condition adductor type spasmodic dysphonia (ADSD)? **Yes or No**

Anal Fissures

- a. Has the member previously tried topical nitrates? **Yes or No**

Blepharospasm

- a. Is the blepharospasm associated with dystonia? **Yes or No**

Other: _____

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****Complete page 3 ONLY for Subsequent (Renewal) requests ****

General Information

- a. How many units are being prescribed? _____
- b. What parts of the body will the medicine be injected into? _____
- c. Has the member received another botulinum toxin within the past 4 months? **Yes or No**

Diagnosis Information (please select diagnosis and provide requested information below the diagnosis):

- Cervical Dystonia/Spasmodic Torticollis
- Upper limb spasticity
- Lower limb spasticity
- Strabismus
- Blepharospasm
- Primary Axillary Hyperhidrosis
- Chronic Migraine
 - Has the member's migraine frequency decreased by at least 7 days per month compared to pre-treatment level? **Yes or No**
 - Has the member's migraine frequency decreased at least 100 hours per month compared to pre-treatment level? **Yes or No**
- *Please submit chart documentation if answering Yes to either of the above****
- Frey's syndrome
- Post-surgical Head and/or Neck Pain
- Hemifacial or Facial spasm
- Urinary Incontinence due to Neurogenic Detrusor Overactivity
- Overactive Bladder
- Focal and segmental limb dystonia or spasm
- Tourette Syndrome
- Hyperhidrosis of the palms
- Oromandibular Dystonias
- Anal Fissures
- Achalasia
- Dysphagia
- Sialorrhea (disturbance of salivary gland)
 - a. Does the member also have a neurological condition or impairment (e.g., Parkinson's Disease, Amyotropic Sclerosis (ALS) or Cerebral Palsy)? **Yes or No**
- Spasticity
 - a. What medical condition is the spasticity due to? _____
 - b. If due to Cerebral Palsy, does the member have dynamic spasticity? **Yes or No**
- Spasmodic Dysphonia (laryngeal dystonia)
 - a. Is the condition adductor type spasmodic dysphonia (ADSD)? **Yes or No**

Physician office's signature _____ Print Name _____

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