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 Toricollis  □ 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____________________________

*Form must be completed and signed by physician or licensed representative from the physician’s office.
Member Name: ____________________________ Member ID: ____________________________ Member DOB: ____________________________
Drug Name: ____________________________ Strength: __________________ Directions: ____________________________
Physician Name: ____________________________ Physician Phone #: __________________ Specialty: ____________________________
Physician Fax #: ____________________________ Pharmacy Name: ____________________________ Pharmacy Phone: ____________________________

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☐ 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: ____________________________

Physician office's signature ____________________________ Print Name ____________________________

*Form must be completed and signed by physician or licensed representative from the physician’s office.*
Member Name: __________________________ Member ID: _______________ Member DOB: ______________
Drug Name: ___________________________ Strength: _______________ Directions: ________________________
Physician Name: _________________________ Physician Phone #: __________________ Specialty: _________________
Physician Fax #: _________________________ Pharmacy Name: ____________________________ Pharmacy Phone: _______________

**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, Amyotrophic 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______________________________
*Form must be completed and signed by physician or licensed representative from the physician’s office.