

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 concomitant treatment with any other botulin toxin agent? **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** \_\_\_\_\_

**\*Form must be completed and signed by physician or licensed representative from the physician's office.**

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Physician Name: \_\_\_\_\_ Physician Phone #: \_\_\_\_\_ Specialty: \_\_\_\_\_  
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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: \_\_\_\_\_

Physician office's signature \_\_\_\_\_ Print Name \_\_\_\_\_

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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 concomitant treatment with any other botulin toxin agent? **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** \_\_\_\_\_

**\*Form must be completed and signed by physician or licensed representative from the physician's office.**