

**Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form**



Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	Name
ID Number	Specialty
D.O.B. ____/____/____ MM/DD/YYYY <input type="checkbox"/> Male <input type="checkbox"/> Female	Address
Diagnosis	City /State/Zip
Drug Name BOTOX	Phone:
Dose and Quantity	Fax:
Directions	NPI
Date of Service(s)	Contact Person
	Contact Person Phone / Ext.

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____ kg
 Patient Height: _____ ft _____ inches

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?
 Yes No *If No, a prior authorization is not required through this process.*

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

- If primary, continue with question set.
- If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Criteria Questions:

1. Will Botox be used in combination with other botulinum toxins such as Dysport, Myobloc, or Xeomin? Yes* No

**If YES, please specify the medication:* _____

2. What is the patient's diagnosis?

- | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------|
| <input type="checkbox"/> Achalasia | <input type="checkbox"/> Hemifacial spasms | <input type="checkbox"/> Spasmodic torticollis (clonic twisting of head) |
| <input type="checkbox"/> Blepharospasm associated with dystonia | <input type="checkbox"/> Hereditary spastic paraplegia | <input type="checkbox"/> Spasticity (upper and/or lower limb) |
| <input type="checkbox"/> Chronic anal fissures | <input type="checkbox"/> Hyperhidrosis | <input type="checkbox"/> Sphincter of Oddi dysfunction |
| <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Neuromyelitis optica | <input type="checkbox"/> Strabismus |
| <input type="checkbox"/> Essential tremor | <input type="checkbox"/> Orofacial dyskinesia | |
| <input type="checkbox"/> Facial nerve (VII) disorder | <input type="checkbox"/> Spastic hemiplegia | |
| <input type="checkbox"/> Dystonia (<i>select type</i>): <input type="checkbox"/> Cervical <input type="checkbox"/> Focal task specific <input type="checkbox"/> Laryngeal (spasmodic dysphonia) <input type="checkbox"/> Writer's cramp | | |
| <input type="checkbox"/> Other type (<i>please specify</i>): _____ | | |
| <input type="checkbox"/> Excessive salivation | | |

a. Is this diagnosis secondary to Parkinson's disease? Yes No

Incontinence OR Overactive Bladder (OAB), **please select diagnosis below:**

Incontinence: Please answer the following questions:

- a. Does the patient have a neurological condition such as multiple sclerosis (MS) or spinal cord injury? Yes No
- b. Has the patient been on Botox continuously for the last **6 months, excluding samples**? Yes No*

**If NO, please answer the following questions:*

- i. Is the patient intolerant to anticholinergics? Yes No
- ii. Has the patient had an inadequate response to an anticholinergic? Yes No

Overactive Bladder (OAB): Please answer the following question:

- a. Has the patient been on Botox continuously for the last **6 months, excluding samples?** Yes No*

**If NO, please answer the following questions:*

- i. Is the patient intolerant to anticholinergics? Yes No
- ii. Has the patient had an inadequate response to an anticholinergic? Yes No

Migraine headaches, chronic

- a. Is Botox being used for prophylaxis (prevention) of chronic migraine? Yes No
- b. Has the patient been on Botox continuously for the last **6 months, excluding samples?** *Please select answer below:*

NO – this is **INITIATION** of therapy, please answer the following questions:

- i. Does the patient have a migraine 15 or more days per month? Yes* No
- *If YES, does the migraine last four or more hours?* Yes No
- ii. Has the patient had a trial of at least eight weeks of **ONE** of the following: divalproex sodium (Depakote, Depakote ER), topiramate (Topamax), gabapentin (Neurontin), amitriptyline (Elavil), or beta-blockers: atenolol, metoprolol, propranolol, timolol or nadolol? Yes No*

If NO, has the patient had a trial of at least eight weeks of **ONE of the following: venlafaxine (Effexor), nimodipine, verapamil, naproxen or other NSAID, or other oral migraine prophylactic therapy considered to be appropriate by the prescriber?* Yes No

YES – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

- i. Since starting Botox, has the patient had a 50% reduction in the frequency of monthly migraines? Yes No

Neurogenic Detrusor Overactivity (NDO)

- a. Has the patient been on Botox continuously for the last **6 months, excluding samples?** Yes No*

**If NO, please answer the following questions:*

- i. Is the patient intolerant to anticholinergics? Yes No
- ii. Has the patient had an inadequate response to an anticholinergic? Yes No

Other diagnosis (please specify): _____

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review (required)

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	Physician Signature	Date
Step 2: Checklist <input type="checkbox"/> Form Completely Filled Out <input type="checkbox"/> Provide chart notes		<input type="checkbox"/> Attach test results
Step 3: Submit	By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979	By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320

Confidentiality notice: This transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of this document is strictly prohibited. If you have received this in error, please notify the sender to arrange for the return of this document.