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

Blue Cross Blue Shield Blue Care Network of Michigan

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 ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**BOTOX**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**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 questionset.

❑ 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:

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?

❑Achalasia
❑Blepharospasm associated with dystonia
❑Chronic anal fissures
❑Dysphagia
❑Essential tremor
❑Facial nerve (VII) disorder
❑Hemifacial spasms
❑Hereditary spastic paraplegia
❑Hyperhidrosis
❑Neuromyelitis optica
❑Orofacial dyskinesia
❑Spastic hemiplegia
❑Spasmodic torticollis (clonic twisting of head)
❑Spasticity (upper and/or lower limb)
❑Sphincter of Oddi dysfunction
❑Strabismus

❑Dystonia

a. Which type of dystonia is the patient experiencing? ***Please select one of the following below:***

❑Cervical ❑Focal task specific ❑Laryngeal (spasmodic dysphonia) ❑Writer's cramp

❑Other type of dystonia ***(please specify)***: _____

❑ 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 4 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 a beta blocker: atenolol/metoprolol/ propranolol/timolol/nadolol? ❑Yes ❑No*

If NO, has the patient had a trial of at least 8 weeks of one of the following: venlafaxine (Effexor), nimodipine, verapamil, naproxen, other NSAID, or other oral/injectable 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	❑ Form Completely Filled Out ❑ Provide chart notes	❑ 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**