Jefferson Health Plans

MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM

Botulinum Toxins - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a renewal request? If NO, go to 3.

☐ Yes ☐ No

Q2. FOR RENEWALS: Has the prescriber provided medical documentation to support the need for repeat treatment(s) occurring no sooner than every 3 months? If yes, go to 15.

☐ Yes ☐ No

Q3. FOR INITIAL REQUESTS: Is the patient greater than or equal to 18 years of age with a documented diagnosis of overactive bladder (OAB) with symptoms of urge urinary incontinence or urinary incontinence due to detrusor overactivity associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis)?

☐ Yes ☐ No

Q4. Has the patient had an inadequate response or intolerance to at least one anticholinergic medication (e.g., oxybutynin / oxybutynin ER, tolterodine / tolterodine ER, trospium / trospium ER, etc.)?

☐ Yes ☐ No

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Member Name:	**Prescriber Name:**

Q5. Is the patient greater than or equal to 18 years of age with a documented diagnosis of migraine headaches occurring greater than or equal to 15 days per month with headache lasting 4 hours a day or longer?

☐ Yes ☐ No

Q6. Has the patient had an inadequate response or intolerance to at least 2 different classes of prophylactic medications (i.e., beta blockers [such as propranolol, metoprolol], antidepressants [such as amitriptyline, venlafaxine], antiepileptics [such as topiramate, valproic acid or its derivatives, verapamil])?

☐ Yes ☐ No

Q7. Does the patient have a documented diagnosis of sialorrhea associated with disorders of the nervous system or neurologic dysfunction?

☐ Yes ☐ No

Q8. Has the patient had an inadequate response or intolerance to at least 1 anticholinergic medication (e.g., glycopyrrolate)?

☐ Yes ☐ No

Q9. Is the patient greater than or equal to 18 years of age with a documented diagnosis of severe primary axillary hyperhidrosis?

☐ Yes ☐ No

Q10. Is the patient greater than or equal to 18 years of age with a documented diagnosis of upper limb spasticity where the drug is being used to decrease the severity of increased muscle tone [in elbow flexors (biceps), wrist flexors (flexor carpi radialis and flexor carpi ulnaris), finger flexors (flexor digitorum profundus and flexor digitorum sublimis), or thumb flexors (adductor pollicis and flexor pollicis longus)] or lower limb spasticity where the drug is being used to decrease the severity of increased muscle tone [in ankle or toe flexors (gastrocnemius, soleus, tibialis posterior, flexor hallucis longus, flexor digitorum longus, brachialis, brachioradialis, pronator teres, pronator quadratus, lumbricals, interossei, flexor pollicis brevis, and opponens pollicis)]?

☐ Yes ☐ No

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Q11. Is the patient greater than or equal to 16 years of age with a documented diagnosis of cervical dystonia where the drug is being used to reduce the severity of abnormal head position and neck pain?

☐ Yes ☐ No

Q12. Is the patient greater than or equal to 12 years of age with a documented diagnosis of blepharospasm or strabismus associated with dystonia?

☐ Yes ☐ No

Q13. Does the patient have a documented diagnosis of spasticity associated with cerebral palsy, hemifacial spasm, or laryngeal dystonia?

☐ Yes ☐ No

Q14. Is the prescribing physician a specialist for the condition (e.g., urologist/neurologist for OAB or urinary incontinence; neurologist for migraine headaches; neurologist or physiatrist for upper limb spasticity, cervical dystonia, or hyperhidrosis; ophthalmologist for blepharospasm or strabismus)?

☐ Yes ☐ No

Q15. Has the prescriber submitted documentation of the proposed injection site(s) and the dose that will be injected into each site?

☐ Yes ☐ No

Q16. Is the dose in accordance with the recommend dosing below and occurring no sooner than every 3 months? Overactive bladder – up to 100 units per treatment; Urinary incontinence – up to 200 units per treatment; Chronic migraine – up to 155 units per treatment; Upper limb spasticity – up to 400 units per treatment; Cervical dystonia – up to 300 units per treatment (up to 50 units per site); Hyperhidrosis – up to 100 units per treatment (up to 50 units per axilla); Blepharospasm – up to 200 units per treatment; Strabismus – up to 25 units per muscle per injection

☐ Yes ☐ No

Q17. Requested Duration:

☐ 12 Months ☐ Other:

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Member Name:	**Prescriber Name:**

Q18. Additional Information:

_____ _____

Prescriber Signature Date

v2025

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