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 through 3 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. Will the member be receiving 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 Toritcollis □ 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)

□ 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. Please document all medications the member has used for the given diagnosis, length of trial and discontinuation reasons.

| **Drug Name** | **Length of trial** (e.g., # days, #months, #years) | **Discontinuation Reason** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

***Continued on p. 2***

**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: _____

□ 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: _____

□ 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**

□ Chronic 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**

□ 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**

**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: _____

□ 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 4 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. Will the member be receiving 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 duration 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

□ Chronic 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**.