



CONTAINS CONFIDENTIAL PATIENT INFORMATION
Botulinum Toxin
Prior Authorization of Benefits (PAB) Form
 Complete form in its entirety and fax to:
 Prior Authorization of Benefits Center at (800) 601- 4829

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

<input type="checkbox"/> Botox <input type="checkbox"/> Dysport <input type="checkbox"/> Myobloc	<input type="checkbox"/> _____	_____	Specify: _____
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7. DIAGNOSIS:

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Yes No Patient has a diagnosis of **Strabismus, Achalasia, or Anal Fissures**
 Yes No Patient has significant drooling and is unable to tolerate scopolamine
 Yes No Patient has one of the following disorders associated with spasticity or Dystonia:
 Blepharospasm Orofacial Dyskinesia (i.e., jaw closure Spasmodic Torticollis
 Hereditary Spastic Paraparesis dystonia) Organic Writer's Cramp
 Multiple Sclerosis Symptomatic Torsion Dystonia Spasmodic Dysphonia / Laryngeal Dystonia
 Schilder's Disease Cervical Dystonia Facial Nerve (VII) Dystonia
 Spasticity from Stroke or Spinal Cord Injury Cerebral Palsy Forms of Upper Motor Neuron Spasticity
 Idiopathic Torsion Dystonia Neuromyelitis Optica
 Spastic Hemiplegia
 Yes No Is this the patient's initial treatment of Cervical Dystonia (spasmodic torticollis)?
 Yes No Is the patient's Cervical Dystonia moderate to severity?
 Yes No Patient has a history of recurrent clonic and/or tonic involuntary contractions of one or more of the following muscles:
 sternocleidomastoid splenius trapezius posterior cervical muscles
 Yes No Patient has sustained head tilt and/or abnormal posturing with limited range of motion in the neck

 Please indicate the duration of the patient's condition: _____
 Yes No Is this request for subsequent injections of botulinum toxin for the treatment of cervical dystonia (spasmodic torticollis)?
 Yes No **If yes, there is a response to the initial treatment documented in the medical records**



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PATIENT NAME: _____ **PATIENT ID #:** _____

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has incontinence related to detrusor overreactivity and incontinence of neurogenic origin (i.e., spinal cord injury, multiple sclerosis) that is inadequately controlled with anticholinergic therapy
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Patient has bladder detrusor sphincter dyssynergia of neurogenic origin

9. PHYSICIAN SIGNATURE

Prescriber or Authorized Signature	Date
<i>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.</i> <small>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</small>	
IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED . If you have received this message by error, please notify us immediately at (800) 338-6180 and destroy the related message or return the document to us at 8407 Fallbrook Avenue AF13, West Hills, CA 91304. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.	