P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
Fax 801-442-3006

selecthealth

PREAUTHORIZATION FORM

Botox®, Dysport™, Myobloc®, and Xeomin®
(onabotulinumtoxinA, abobotuliulinumtoxinA, rimabotulinumtoxinB, and incobotulinumtoxinA)

Therapeutic use: Botulinum toxins reduce muscle tone by inhibiting the release of acetylcholine at the nerve endings
Quantity Limit: 1 injection every 3 months
Authorization Period: 12 months

Patient's name _____

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐ ☐☐☐- ☐☐☐☐ Fax# ☐☐☐- ☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" or answer the following questions:			
1.	Is the patient diagnosed with any of the following disorders (Please check those that apply)?	❑ Yes	❑ No
	❑ Blepharospasm ❑ Cervical dystonia/ spasmodic torticollis ❑ Facial nerve VII disorder (hemifacial spasm) ❑ Strabismus ❑ Equinus foot related to cerebral palsy ❑ Hereditary spastic paraplegia ❑ Infantile cerebral palsy ❑ Neuromyelitis optica ❑ Schilder's disease ❑ Spasticity as a consequence of multiple sclerosis	❑ Spastic hemiplegia ❑ Spasticity related to stroke or spinal cord injury ❑ Idiopathic torsion dystonia ❑ Organic writer's cramp ❑ Orofacial dyskinesia (i.e. jaw closure dystonia) ❑ Laryngeal spasm or laryngeal dysphonia ❑ Symptomatic torsion dystonia ❑ Chronic anal fissures ❑ Achalasia ❑ Frey's Syndrome ❑ Refractory sialorrhea	
2.	Is therapy requested for primary axillary hyperhidrosis? Coverage requires failure of 2 of the 3 following therapies. Please check all that apply.	❑ Yes	❑ No
	❑ Prescription strength topical antiperspirant ❑ Iontophoresis	❑ Oral anticholinergic (oxybutynin, benztropine, glycopyrrolate)	
3.	Has the patient been diagnosed with chronic migraine by a neurologist? If so, please complete the questions below.	❑ Yes	❑ No
a.	Does the patient experience **> 15 headaches/month** lasting **4 hours a day** or longer?	❑ Yes	❑ No
b.	Has the patient tried prophylactic therapy from all of the following therapy classes as listed below? (Please check those that apply.)	❑ Yes	❑ No
	❑Anti-epileptic drugs (i.e. topiramate or valproate) ❑Beta blockers (i.e. propranolol or atenolol)	❑Calcium channel blockers (i.e. verapamil or nimodipine) ❑Tricyclic antidepressants (i.e. amitriptyline or doxepin)	
4.	For urinary incontinence due to neurogenic detrusor overactivity:		
a.	Has the patient suffered a spinal cord injury or is diagnosed with multiple sclerosis?	❑ Yes	❑ No
b.	Has the patient failed therapy on at least two anticholinergic/antimuscarinic medications for urinary incontinence? If so, please list: _____	❑ Yes	❑ No
5.	What therapy is being requested? ❑Botox® ❑Dysport™ ❑Myobloc® ❑Xeomin® Sig:_____		

Please note, onabotulinumtoxinA (J0585), abobotulinumtoxinA (J0586), rimabotulinumtoxinB (J0587), and incobotulinumtoxinA (J0588) are not dose equivalent and are not interchangeable.

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006.
Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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