PRIOR AUTHORIZATION FORM
Botox Dysport Myobloc Xeomin - Commercial

Unless otherwise indicated below, authorization quantities are limited to the manufacturer recommended dosage

SCRIPIUS
a service of selecthealth.
P.O. Box 30192 Salt Lake City, UT 84130

Complete online at www.selecthealth.org/pa or fax back to: 801-650-3279
For questions or clarifications, call: 800-442-3129

Patient Information	
Patient's Name:	Patient's Date of Birth:
Patient's ID:	Patient's Phone #:
Diagnosis Code(s):	
Requesting Provider Information	
Name:	Phone #:
NPI/DEA:	Fax #:
Address:	Supervising Physician (if requesting provider bills under a different provider)
	Name:
	NPI/DEA:
Servicing Provider Information (if different than requesting provider)	
Name of provider or facility:	Phone number:
NPI/DEA:	Address:

Drug Name and Strength:	Directions / SIG:

Q1. What therapy is being requested?

- ☐ Botox
- ☐ Dysport
- ☐ Myobloc
- ☐ Xeomin

Q2. If this request is for Myobloc or Xeomin, has the patient failed BOTH Botox and Dysport?

☐ Yes ☐ No

Q3. Please select an applicable diagnosis:

- ☐ Achalasia
- ☐ Axillary hyperhidrosis
- ☐ Blepharospasm
- ☐ Cervical dystonia/ spasmodic torticollis
- ☐ Chronic anal fissures
- ☐ Organic writer's cramp
- ☐ Orofacial dyskinesia (i.e. jaw closure dystonia)
- ☐ Overactive Bladder
- ☐ Pelvic floor dyssynergia

☐ Chronic Migraine
☐ Equinus foot related to cerebral palsy
☐ Facial nerve VII disorder (hemifacial spasm)
☐ Frey's Syndrome
☐ Hereditary spastic paraplegia
☐ Idiopathic torsion dystonia
☐ Infantile cerebral palsy
☐ Laryngeal spasm or laryngeal dysphonia
☐ Neuromyelitis optica
☐ Pyloroplasty efficacy assessment
☐ Refractory sialorrhea
☐ Schilder's disease
☐ Spastic hemiplegia
☐ Spasticity due to multiple sclerosis
☐ Spasticity related to stroke or spinal cord injury
☐ Strabismus
☐ Symptomatic torsion dystonia
☐ Urinary Incontinence
☐ Other (please specify below)

Q4. If other, please provide the diagnosis code:

Q5. For axillary hyperhidrosis, has the patient failed at least two of the following treatments: prescription strength topical antiperspirant, iontophoresis, topical glycopyrronium, and/or an oral anticholinergic (oxybutynin, benztropine, glycopyrrolate)?

☐ Yes ☐ No

Q6. For chronic migraine, does the patient have 15 or more migraine days per month?

☐ Yes ☐ No

Q7. For chronic migraine, has the patient tried prophylactic therapy on TWO of the following: an antidepressant, an anti-epileptic, or a beta-blocker?

☐ Yes ☐ No

Q8. For chronic migraine, is the patient on CGRP therapy?

☐ Yes ☐ No

Q9. If yes, is the patient still continuing to have at least 15 migraine days per month?

☐ Yes ☐ No

Q10. Has the patient been diagnosed with urinary incontinence from neurogenic detrusor overactivity?

☐ Yes ☐ No

Q11. For urinary incontinence, has the patient suffered a spinal cord injury or is diagnosed with multiple sclerosis?

☐ Yes ☐ No

Q12. For urinary incontinence, does the patient have at least three urinary urgency incontinence episodes and at least 24 micturitions in three days?

☐ Yes ☐ No

Q13. For urinary incontinence, will administration of the medication only be completed after cystoscopy has shown a normal bladder?

☐ Yes	☐ No
Q14. For urinary incontinence, has the patient had a clinical evaluation with urodynamic testing?	
☐ Yes	☐ No
Q15. For urinary incontinence or overactive bladder, has the patient failed therapy on at least ONE anticholinergic/antimuscarinic medications for urinary incontinence? (i.e. ditropan , oxybutynin ,trospium, darifenacin, fesoteradine, solifenacin, or tolterodine)	
☐ Yes	☐ No
Q16. Additional Comments:	

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-650-3279. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

_____ _____

Prescriber Signature Date