AmeriHealth NEW JERSEY

Today's date:	
Date medication needed:	

Prior Authorization Form – **Botulinum Toxins**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Select one: ☐ Botox® ☐ Dysport® ☐ Myobloc® ☐ Xeomin® Check one: ☐ New start ☐ Continued treatment

Number of units to be injected_____

Patient information (please print)

Patient name		Patient ID #		
Address		City	State	Zip
Telephone	Date of birth	Weight		

Physician information (please print)

Prescribing physician		NPI
Office address		
City	State	Zip
Office telephone #	Office contact	Fax #

☐ No delivery requested; physician will use office supply. Authorization only.
☐ Delivery requested to the physician's office.

****A copy of the prescription must accompany the medication request for delivery.****

1. Diagnosis for drug requested (must include ICD-10):_____

2. Patient medical information

For hyperhidrosis only:

a. Is the age of onset of hyperhidrosis younger than 25 years of age? ☐ Yes ☐ No
b. Is focal sweating bilateral and relatively symmetric? ☐ Yes ☐ No
c. Does the patient sweat during sleep? ☐ Yes ☐ No
d. Does the patient have a positive family history of severe primary focal hyperhidrosis? ☐ Yes ☐ No
e. Does the hyperhidrosis significantly impair the patient's participation in daily activities? ☐ Yes ☐ No
f. Does the patient have any underlying disease causing hyperhidrosis? ☐ Yes ☐ No
If yes please specify: _____
g. Which area will be treated? (e.g., palmar, plantar, axillary) _____
h. How many units will be injected into each area?_____

For chronic migraine or probable chronic migraine only:

a. Has a neurologist established the diagnosis of chronic migraine headache? ☐ Yes ☐ No
b. Have the migraines occurred at least 15 days per month for at least 3 months? ☐ Yes ☐ No
c. Does the migraine last at least 4 hours per day? ☐ Yes ☐ No
d. Does the patient have either nausea or sensitivity to light and/or sound with the migraine? ☐ Yes ☐ No
e. How does the patient describe the pain associated with the migraine? (Select all that apply)
- ☐ Moderate-to-severe pain intensity
- ☐ Unilateral pain
- ☐ Pain aggravated by movement or that prohibits movement
- ☐ Throbbing pain

f. Has the patient failed to respond to a 4-week course of at least two agents from the different drug classes listed below? ☐ Yes ☐ No
If yes, list the drug(s) and the duration(s) below:
1. Tricyclic antidepressants; (list drug[s]/duration[s]) _____
2. Serotonin-norepinephrine reuptake inhibitors; (list drug[s]/duration[s]) _____
3. Selective serotonin reuptake inhibitors; (list drug[s]/duration[s]) _____
4. Anticonvulsants; (list drug[s]/duration[s]) _____
5. Beta-blockers; (list drug[s]/duration[s]) _____
6. Calcium channel blockers; (list drug[s]/duration[s]) _____
7. Other drug(s); (list drug[s]/duration[s]) _____

3. Prescription information:

Dosage_____Frequency_____ Refill x_____month(s)

Physician's signature _____

Please fax this completed form to 215-761-9580.