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**

□ 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: __________________

<u>Complete page 4 ONLY for Subsequent (Renewal) requests **</u>**

<u>General Information</u>

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**

<u>Diagnosis Information</u> <u>(please select diagnosis and provide requested information below the diagnosis</u>):

□ 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

□ 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**.