BlueCross BlueShield Federal Employee Program.

BOTOX
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Botox

(onabotulinum toxin A)

NOTE: Form must be completed in its **entirety** for processing

Please select strength(s): ❑100 IU vial qty _____ per 90 days ❑200 IU vial qty _____ per 90 days

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Will Botox be used in combination with other botulinum toxins such as Dysport, Myobloc, or Xeomin? ❑Yes* ❑No
   If YES, please specify the medication: _____

2. What is the patient's diagnosis?

❑Achalasia
❑Blepharospasm associated with dystonia
❑Chronic anal fissures
❑Dysphagia
❑Essential tremor
❑Facial nerve (VII) disorder
❑Hemifacial spasms
❑Hereditary spastic paraplegia
❑Hyperhidrosis
❑Neuromyelitis optica
❑Orofacial dyskinesia
❑Spastic hemiplegia
❑Spasmodic torticollis (clonic twisting of head)
❑Spasticity (upper and/or lower limb)
❑Sphincter of Oddi dysfunction
❑Strabismus

❑Dystonia

a. Which type of dystonia is the patient experiencing? ***Please select one of the following below:***
❑Cervical ❑Focal task specific ❑Laryngeal (spasmodic dysphonia) ❑Writer's cramp
❑Other type of dystonia ***(please specify)***: _____

❑Excessive salivation

a. Is this diagnosis secondary to Parkinson's disease? ❑Yes ❑No

❑Incontinence **OR** Overactive Bladder (OAB): ***Please select diagnosis below:***

❑**Incontinence**: Please answer the following questions:

a. Does the patient have a neurological condition such as multiple sclerosis (MS) or spinal cord injury? ❑Yes ❑No
b. Has the patient been on this medication continuously for the last **6 months** excluding samples? ❑Yes ❑No*
   If NO, please answer the following questions:
   i. Is the patient intolerant to anticholinergics? ❑Yes ❑No
   ii. Has the patient had an inadequate response to an anticholinergic? ❑Yes ❑No

❑**Overactive bladder (OAB):** Please answer the following question:

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ❑Yes ❑No*
   If NO, please answer the following questions:
   i. Is the patient intolerant to anticholinergics? ❑Yes ❑No
   ii. Has the patient had an inadequate response to an anticholinergic? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program.

BOTOX
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Migraine headaches, chronic

a. Is this medication being used for prophylaxis (prevention) of chronic migraines? ❑Yes ❑No

b. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

i. Does the patient have a migraine 15 or more days per month? ❑Yes***** ❑No

****If YES***, does the migraine last 4 or more hours? ❑Yes ❑No

ii. Has the patient had a trial of at least 8 weeks of one of the following: divalproex sodium (Depakote, Depakote ER), topiramate (Topamax), gabapentin (Neurontin), amitriptyline (Elavil), or a beta blocker: atenolol/metoprolol/ propranolol/timolol/nadolol? ❑Yes ❑No*****

****If NO***, has the patient had a trial of at least 8 weeks of one of the following: venlafaxine (Effexor), nimodipine, verapamil, naproxen, other NSAID, or other oral/injectable migraine prophylactic therapy considered to be appropriate by the prescriber? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

i. Since starting Botox, has the patient had a 50% reduction in the frequency of monthly migraines? ❑Yes ❑No

❑ Neurogenic detrusor overactivity (NDO)

a. Has the patient been on this medication continuously for the last **6 months** excluding samples? ❑Yes ❑No*****

****If NO***, please answer the following questions:

i. Is the patient intolerant to anticholinergics? ❑Yes ❑No

ii. Has the patient had an inadequate response to an anticholinergic? ❑Yes ❑No

❑Other ***(please specify)***: _____

BlueCross BlueShield Federal Employee Program.

BOTOX
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***