



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Botox® (Botulinum Toxin Type A)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:

Physician Name:

Q6. For diagnoses of blepharospasm or strabismus: Is the patient equal to or greater than 12 years old?

Yes No

Q7. For diagnoses of Cervical Dystonia: Is the patient equal to or greater than 16 years old?

Yes No

Q8. For a diagnosis of Severe Primary Axillary Hyperhidrosis (SPA): Is the patient equal to or greater than 18 years old?

Yes No

Q9. For diagnosis of Severe Primary Axillary Hyperhidrosis (SPA): Please indicate the patient's score on the Hyperhidrosis Disease Severity Scale (HDSS)

1 2 3 4

Q10. For a diagnosis of Severe Primary Axillary Hyperhidrosis (SPA): Has the patient tried and failed a course of treatment using prescription antiperspirants?

Yes No Unknown

Q11. What dosage is intended to be used with this patient?

- 100 units or less
- Between 100 and 200 Units
- Between 200 and 300 Units
- Greater than 300 Units

Q12. Deliver to:

Physician's Office Home Delivery

Q13. Delivery date needed:

Physician Signature

Date