UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

# Botulinum Toxins

| **Member and Medication Information**<br>* indicates required field | |
|---|---|
| *Member ID: | *Member Name: |
| *DOB: | *Weight: |
| *Medication Name/ Strength: | |
| ☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified. | |
| *Directions for use: | |
| **Provider Information**<br>* indicates required field | |
| *Requesting Provider Name: | *Requesting Prescriber NPI: |
| Address: | |
| *Contact Person: | *Office Phone: |
| *Office Fax: | *Office Email: |
| **Medically Billed Information**<br>* indicates required field for all medically billed products | |
| *Diagnosis Code: | *HCPCS Code: |
| *Dosing Frequency: | *HCPCS Units per Dose: |
| Servicing Provider Name: | NPI: |
| Servicing Provider Address: | |
| Facility/Clinic Name: | NPI: |
| Facility/Clinic Address: | |
| Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays. | |

**Criteria for Approval:** (*All* of the following criteria must be met:)

- ☐ The patient is 19 years and older: Approval considered only for FDA-approved indications, doses, and dosing intervals
- ☐ The patient is 18 years and younger:
  - ☐ Approval considered for FDA-approved indications, doses, and dosing intervals **OR**
  - ☐ Approval may be considered for common, accepted, standard-of-care uses if the request is accompanied by sound clinical rationale and supporting literature (included with this request).

**Chronic Migraine Prophylaxis Additional Criteria:**

- ☐ Trial and failure of one agent from 2 of the 4 following drug classes:

| **Medication/Dose (only those FDA-approved or compendia-recommended for migraine prophylaxis):**<br>*Trial must be a maximum dose* | **Details of Trial and Failure**<br>Trial must be at a minimum of two months | **Chart Note Page #** |
|---|---|---|
| **CGRP:**<br>Dose: | | |

| | | |
|---|---|---|
| **Beta-Blocker:**<br>Dose: | | |
| **Anti-epileptic**<br>**Valproate or Topiramate:**<br>Dose: | | |
| **Tricyclic Antidepressant or**<br>**Venlafaxine:**<br>Dose: | | |

☐ Additionally for concurrent therapy with a CGRP antagonist: The patient is still experiencing ≥15 migraine days per month while taking a CGRP antagonist for chronic migraine prophylaxis

**Reauthorization Criteria:**

☐ Updated letter of medical necessity or updated chart notes demonstrating positive clinical response.

**Initial Authorization:** Up to six (6) months
**Reauthorization:** Up to one (1) year

**Note:**

- Dysport (J0586) does not require Prior Authorization for patients 2-17 years of age
- Claims submitted through pharmacy point of sale will not be covered
- Use appropriate HCPCS code for billing:
  Coverage and Reimbursement code lookup: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

**PROVIDER CERTIFICATION**

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date