State of Oklahoma
Oklahoma Health Care Authority
Botulinum Toxins Prior Authorization Form

BILLING INFORMATION

Member Name: ___________________________________ ***Date of Birth:*** ___________________ ***Weight:*** __________

Member ID#: _________________________________ ***HCPCS Code:*** _______________ ***CPT Code:*** _______________

Dose: ___________________________ ***Frequency:*** ________________________ ***Start Date:*** _______________________

Provider Name: ____ ***Medical Specialty:*** ______________________________

OHCA Provider #: ______________________ ***Phone:*** _________________________ ***Fax:*** _____________________

TO BE COMPLETED BY PRESCRIBER

Diagnosis: ____ *(Diagnosis is required for all Botulinum Toxins)*

Chronic Migraine Diagnosis: please complete the following section. (Only Botox® will be approved.)

1. What is the monthly frequency of migraines?___________ What is the average duration of migraines?_________ hrs.
2. Have medical conditions known to cause or exacerbate migraines been ruled out/treated? Yes______ No______
3. Is the member chronically taking medications or other substances (which may be contained in food or drink items) known to cause or exacerbate migraines such as caffeine, narcotics, NSAIDs, APAP, or decongestants, etc.?
   Yes ______ No ______
4. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anti-convulsants, anti-depressants, etc.)? Please list:
   Medication____________________________ Date Span______________ Dosing ___________________________
   Medication____________________________ Date Span______________ Dosing ___________________________
   Medication ____________________________ Date Span______________ Dosing ___________________________
5. Has the member been evaluated by a neurologist for chronic migraine headaches within the past 6 months?
   Yes___ No___ If yes, please include name of neurologist recommending Botox® treatment ______________________
6. Does the member currently use tobacco? Yes ______ No ______

Overactive Bladder Diagnosis: please complete the following section. (Only Botox® will be approved.)

1. Number of urinary incontinence episode(s) per day while on medication? ___________
2. Have urodynamic studies been performed? Yes_______ No_______ If yes, include date___________
3. Has member participated in behavioral therapy? Yes______ No ______ If yes, please give length of therapy and reason for therapy failure? ____
4. Has member used at least three anti-muscarinic medications for the treatment of overactive bladder?
   Medication____________________________ Date Span______________ Dosing ________________________
   Medication____________________________ Date Span______________ Dosing ________________________
   Medication ____________________________ Date Span______________ Dosing ________________________
5. Does the member or caregiver have the ability to catheterize? Yes ______ No ______

Neurogenic Bladder Diagnosis: please complete the following section. (Only Botox® will be approved.)

1. Have urodynamic studies been performed? Yes_______ No_______ If yes, include date___________
2. What is the specific underlying pathological urologic dysfunction (such as small bladder capacity <400 cc, high detrusor pressure, etc)?____
3. Does member keep diary of fluid intake, voiding/catheterization times and amounts or number of diapers/pads used daily? Yes_____ No ______
4. Clinical reason for failure of anticholinergic medication therapy? ____
5. Does the member have physical and cognitive ability to self-catheterize or access to caregiver? Yes ______ No ______

Prescriber Signature: ____ **Date:** ______________________________

Please do not send in chart notes. Specific information/documentation will be requested if necessary.

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*