State of Oklahoma
SoonerCare
Botulinum Toxins Prior Authorization Form

Member Name:_____ ***Date of Birth:***_____ ***Member ID#:***_____

Drug Information

Dose:_____ ***Frequency:***_____ ***Start Date:***_____

HCPCS Code:_____ ***Billing Units Per Dose:***_____ ***J.W. Units:***_____

CPT Code:_____ ***Member's Weight:***_____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Clinical Information

Page 1 of 2—Please complete and return <u>all</u> pages. *Failure to complete all pages will result in processing delays.*

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

Please note: Botox® and Dysport® are the preferred products for SoonerCare

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

1. Have the following medical conditions known to cause or exacerbate migraines been ruled out/treated?
   a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis)? Yes☐ No☐
   b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma)? Yes☐ No☐
2. Has migraine headache exacerbation secondary to the following medication therapies or conditions been ruled out and/or treated?
   a. Hormone replacement therapy or hormone-based contraceptives? Yes☐ No☐
   b. Chronic insomnia? Yes☐ No☐
   c. Obstructive sleep apnea? Yes☐ No☐
3. Does member have any contraindications to Botox injections? Yes☐ No☐
4. Number of headache days per month?_____
5. Number of migraine days per month?_____
   a. How long has the member had chronic migraines at the frequency listed above?_____ months
6. What is the average duration of migraines?_____ hours
7. Has the member failed at least 2 different types of medications typically used for migraine prevention [e.g., select antihypertensives (such as beta-blockers), select anticonvulsants (such as valproate or topiramate), select antidepressants (such as amitriptyline or venlafaxine)]? Yes☐ No☐ If yes, please list:
   Medication_____ Date Span_____ Dosing_____
   Medication_____ Date Span_____ Dosing_____
8. Is the member taking any of the following medications known to cause medication overuse or rebound headaches in the absence of intractable conditions known to cause chronic pain?
   a. Decongestants (alone or in combination products)? Yes☐ No☐
   b. Combination analgesics containing caffeine and/or butalbital? Yes☐ No☐
   c. Opioid-containing medications? Yes☐ No☐
   d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes☐ No☐
   e. Ergotamine-containing medications? Yes☐ No☐
   f. Triptans? Yes☐ No☐
9. If member is taking any of the medication(s) listed in Question 8, please list the medication(s) and the number of days per month taken:_____
10. If member is taking any of the medication(s) listed in Question 8, please provide additional information to support member's need for continued use of medication(s) known to cause overuse or rebound headaches:
    _____

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>

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

<u>CONFIDENTIALITY NOTICE</u>

OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Botulinum Toxins Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Clinical Information

Page 2 of 2—Please complete and return all pages. *Failure to complete all pages will result in processing delays*.

Chronic Migraine Diagnosis Continued:

11. Is the member taking any medications that are likely to be the cause of the headaches? Yes☐ No☐
12. 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:_____
13. If applicable, are other aggravating factors that contribute to the development of episodic/chronic migraine headaches being treated (e.g., smoking)? Yes☐ No☐ NA☐
14. Will member use botulinum toxin concurrently with a calcitonin gene-related peptide (CGRP) inhibitor for the prevention of migraine? 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 3 anti-muscarinic medications for the treatment of overactive bladder? Yes☐ No☐
   If yes, please list:
   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☐

Please complete and return all pages. Failure to complete all pages will result in processing delays.

Prescriber Signature:_____ Date:_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.

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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.*