Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Botulinum Toxins

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

Health Partners Plans 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 NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	
HPP's maximum approval time is 12 months but may be less depending on the drug.		

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the member prescribed the Botulinum Toxin for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication, excluding a cosmetic condition

☐ Yes ☐ No

Q2. Is there documentation of the proposed injection site(s) and the dose that will be injected into each site?

☐ Yes ☐ No

Q3. Is the age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q4. Has this plan authorized this medication in the past for this member (for example, previous authorization is on file under this plan)?

☐ Yes ☐ No

Q5. Is the frequency of injection consistent with the dosing and duration of therapy limits?

☐ Yes ☐ No

Q6. Do all of the following conditions apply to the member: A) Tolerability and a positive response to the medication, and B) the symptoms returned to such a degree that repeat injection is required? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q7. Does the frequency of injection exceed the dosing and duration of therapy limits?

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☐ Yes ☐ No

Q8. Do all of the following conditions apply to the member: A) the previous treatment was well tolerated but inadequate, and B) medical literature supports more frequent dosing intervals as safe and effective for the diagnosis and requested dose? Note: The prescriber must submit documentation.

☐ Yes ☐ No

Q9. Are all required documentation attached to this request?

☐ Yes ☐ No

Q10. Is this request for a non-preferred agent?

☐ Yes ☐ No

Q11. Does the member have a documented history of therapeutic failure, contraindication or intolerance of the preferred botulinum toxins approved for the indication?

☐ Yes ☐ No

Q12. Does the member have a diagnosis of chronic spasticity?

☐ Yes ☐ No

Q13. Is the member 18 years of age or older?

☐ Yes ☐ No

Q14. Does the member have documented therapeutic failure, contraindication or intolerance to one oral medication for spasticity?

☐ Yes ☐ No

Q15. Will use the requested botulinum toxin in conjunction with other appropriate therapeutic modalities such as physical therapy, occupational therapy, gradual splinting, etc ?

☐ Yes ☐ No

Q16. If the beneficiary developed contractures, has the member been considered for surgical intervention?

☐ Yes ☐ No

Q17. Will the requested medication be used in conjunction with other appropriate therapeutic modalities such as physical therapy, occupational therapy, gradual splinting, etc?

☐ Yes ☐ No

Q18. Is the member 12 years of age or older?

☐ Yes ☐ No

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Q19. Does the member have a diagnosis of axillary hyperhidrosis?

☐ Yes ☐ No

Q20. Does the member have a history of therapeutic failure, contraindication or intolerance to a topical agent such as 20 percent aluminum chloride?

☐ Yes ☐ No

Q21. Does the member have a diagnosis of chronic migraine headache?

☐ Yes ☐ No

Q22. Does the member have a history of therapeutic failure to at least one migraine preventive medication from at least two of the following three classes (e.g. beta-blockers, calcium channel blockers, tricyclic antidepressants or anticonvulsant medications)?

☐ Yes ☐ No

Q23. Does the member have a history of chronic migraine headache not attributed to other causes including medication overuse?

☐ Yes ☐ No

Q24. Does the member have a diagnosis of urinary incontinence due to detrusor over activity associated with a neurologic condition?

☐ Yes ☐ No

Q25. Does the member have a history of therapeutic failure, contraindication, or intolerance to at least one anticholinergic medication used in the treatment of urinary incontinence?

☐ Yes ☐ No

Q26. Does the member have a diagnosis of overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency?

☐ Yes ☐ No

Q27. Does the member have a history of therapeutic failure, contraindication, or intolerance to at least 2 agents (such as antimuscarinics or beta-3 adrenergic agonists) used in the treatment of overactive bladder?

☐ Yes ☐ No

Q28. Are all required documentation attached to this request?

☐ Yes ☐ No

Q29. Requested Duration:

☐ 12 Months

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Patient Name:	Prescriber Name:

Q30. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2023