BlueCross BlueShield Federal Employee Program

# BOTOX
# PRIOR APPROVAL REQUEST

**Send completed form to:**
**Blue Shield of California**
**Fax: 1-855-895-3504**

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

## CARDHOLDER / PATIENT INFORMATION

Cardholder Name: _____ / _____ / _____
First MI Last

Patient Name: _____ / _____ / _____
First MI Last

Patient Address: _____
Street City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ____ F ____

**R** | | | | | | | | | |
Cardholder Identification Number

## PHYSICIAN COMPLETES

**Diagnosis for which BOTOX is being prescribed:**

- ❑ Achalasia
- ❑ Anal fissures (chronic)
- ❑ Blepharospasm associated with dystonia
- ❑ Dysphagia
- ❑ Dystonia Type: ❑Cervical ❑Writer's Cramp ❑Focal task specific ❑Laryngeal ❑Other:_____
- ❑ Facial Nerve (VII) disorder
- ❑ Hemifacial spasms
- ❑ Hereditary spastic paraplegia
- ❑ Hyperhidrosis
- ❑ Incontinence ***(please answer the 3 additional questions below)***
  a. Does the patient have a neurological condition such as multiple sclerosis (MS) or spinal injury? ❑Yes ❑No
  b. Is the patient intolerant to anticholinergics? ❑Yes ❑No
  c. Has the patient had an inadequate response to an anticholinergic? ❑Yes ❑No
- ❑ **Lower** limb spasticity
- ❑ Migraine headache (chronic) ***(please answer the additional questions below)***
  a. Is this being used for prophylaxis (prevention) of chronic migraine? ❑Yes ❑No
  ❑**Initiation of therapy**: Does the patient have migraine/headache 15 or more days per month? ❑Yes ❑No
  Does the migraine/headache last 4 or more hours? ❑Yes ❑No
  ❑**Continuation of therapy:** Has the frequency of migraines decreased to < 15 days/month? ❑Yes ❑No
- ❑ Neuromyelitis optica
- ❑ Orofacial dyskinesia
- ❑ Overactive bladder (OAB) ***(please answer the additional 2 questions below)***
  a. Is the patient intolerant to anticholinergics? ❑Yes ❑No
  b. Has the patient had an inadequate response to an anticholinergic? ❑Yes ❑No
- ❑ Spasmodic torticollis (clonic twisting of head)
- ❑ Spasticity (upper and lower limbs) due to multiple causes (i.e. cerebral palsy, stroke, multiple sclerosis (MS) and post brain and spine cord injury
- ❑ Spastic hemiplegia
- ❑ Sphincter of Oddi dysfunction
- ❑ Strabismus
- ❑ **Upper** limb spasticity
- ❑ **Other Diagnosis** (please specify)_____

Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

_____ ( _____ ) _____ ( _____ ) _____
Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____/ _____ / _____
Prescriber's NPI Physician Signature Date