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:

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

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