SoonerCare
Oklahoma Health Care Authority

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

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)*

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 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 ☐
3. 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 ☐
4. 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. Butalbital-containing medications? Yes ☐ No ☐
   b. Opioid-containing medications? Yes ☐ No ☐
   c. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)?
      Yes ☐ No ☐
   d. Ergotamine-containing medications? Yes ☐ No ☐
   e. Triptans? Yes ☐ No ☐

   If yes, to <u>any</u> of medications above, please list the medication(s) and the number of days per month taken: _____
5. Has the member failed at least 3 different types of medications typically used for migraine prevention (antihypertensives, anticonvulsants, antidepressants, etc)? Yes ☐ No ☐ If yes, please list:
   Medication_____ Date Span_____ Dosing _____
   Medication_____ Date Span_____ Dosing _____
   Medication _____ Date Span_____ Dosing _____
6. 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:_____
7. 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_____

Please complete and return <u>all</u> pages. Failure to complete all pages will result in processing delays.

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>	<u>CONFIDENTIALITY NOTICE</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	*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.*

SoonerCare
Oklahoma Health Care Authority

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

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

TO BE COMPLETED BY PRESCRIBER

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

Overactive Bladder Diagnosis: please complete the following section, continued.

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 <u>all</u> 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.

<u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u>	<u>CONFIDENTIALITY NOTICE</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	*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.*