BlueCross BlueShield of North Carolina

Botulinum Toxin Injection

abobotulinumtoxinA (Dysport®), incobotulinumtoxinA (Xeomin®), onabotulinumtoxinA (Botox®), rimabotulinumtoxinB (Myobloc®), daxibotulinumtoxinA-lanm (Daxxify™)

FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PRIOR REVIEW/CERTIFICATION REQUEST FOR SERVICES FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility # or NPI #**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #			

PLACE OF SERVICE: ☐ Home Infusion ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE:	**CPT/Other billing code:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

Please select the requested medication and answer the following questions for <u>INITIAL</u> coverage:

*See pages 7-8 for continuation coverage

☐ Botox – J0585 ☐ Dysport – J0586 ☐ Xeomin – J0588
☐ Daxxify – J0589 ☐ Myobloc – J0587

1. Will the requested medication be used for cosmetic purposes (e.g., glabellar lines, wrinkles)?.....☐ Yes ☐ No
2. Will the patient be receiving botulinum toxin more frequently than every 12 weeks?.....☐ Yes ☐ No
3. Does the patient have a diagnosis of **blepharospasm**?.....☐ Yes ☐ No

   If YES, please answer the following questions:

   a. Is the patient 12 years of age or older?.....☐ Yes ☐ No
   b. Is the request for Botox, Daxxify, or Myobloc?.....☐ Yes ☐ No
      i. **If YES,** is the patient 18 years of age or older?.....☐ Yes ☐ No

      If YES, please answer the following questions:

      1. Is the patient's blepharospasm associated with dystonia or facial nerve (VII) disorders (including benign essential blepharospasm and hemifacial spasm)?.....☐ Yes ☐ No
      2. Has the patient tried and had an inadequate response with Xeomin?.....☐ Yes ☐ No

         If YES, medical record documentation required.
      3. Does the patient have a clinical contraindication or intolerance to Xeomin? ☐ Yes ☐ No

         If YES, medical record documentation required.

****continued on page 2; please complete and sign page 6 for prior authorization request****

Botulinum Toxin Injection – *continued*

4. Does the patient have a diagnosis of **hemifacial spasm**?.....☐ Yes ☐ No

5. Does the patient have a diagnosis of **cervical dystonia** (spasmodic torticollis: congenital, due to childbirth injury, or traumatic injury)?.....☐ Yes ☐ No

   If YES, please answer the following questions:
   a. Is the patient 16 years of age or older?.....☐ Yes ☐ No
   b. Is the patient's cervical dystonia associated with sustained head tilt or abnormal posturing with limited range of motion in the neck?.....☐ Yes ☐ No
   c. Does the patient have a history of recurrent involuntary contraction(s) of one or more of the muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, or posterior cervical muscles)?.....☐ Yes ☐ No
   d. Is the request for Botox, Daxxify, or Myobloc?.....☐ Yes ☐ No
      If YES, please answer the following questions:
      i. Has the patient tried and had an inadequate response with Xeomin?.....☐ Yes ☐ No
         If YES, medical record documentation is required.
      ii. Has the patient tried and had an inadequate response with Dysport?.....☐ Yes ☐ No
         If YES, medical record documentation is required.
      iii. Does the patient have a clinical contraindication or intolerance to BOTH Xeomin AND Dysport?.....☐ Yes ☐ No
         If YES, medical record documentation is required.

6. Does the patient have a diagnosis of **dystonia**?.....☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Is the patient 18 years of age or older?.....☐ Yes ☐ No
   b. Does the patient have any of the following focal dystonias:
      i. Focal upper-limb dystonia (e.g., organic writer's cramp)?.....☐ Yes ☐ No
      ii. Oromandibular dystonia (e.g., orofacial dyskinesia, Meige syndrome)?.....☐ Yes ☐ No
      iii. Laryngeal dystonia (e.g., adductor spasmodic dysphonia)?.....☐ Yes ☐ No
      iv. Idiopathic (primary or genetic) torsion dystonia?.....☐ Yes ☐ No
      v. Symptomatic (acquired) torsion dystonia?.....☐ Yes ☐ No
   c. Does the patient's dystonia result in functional impairment (interference with joint function, mobility, communication, nutritional intake) with or without pain?.....☐ Yes ☐ No
   d. Is the request for Botox, Daxxify, or Myobloc?.....☐ Yes ☐ No
      If YES, please answer the following questions:
      i. Has the patient tried and had an inadequate response with Xeomin?.....☐ Yes ☐ No
         If YES, medical record documentation is required.
      ii. Has the patient tried and had an inadequate response with Dysport?.....☐ Yes ☐ No
         If YES, medical record documentation is required.
      iii. Does the patient have a clinical contraindication or intolerance to BOTH Xeomin AND Dysport?.....☐ Yes ☐ No
         If YES, medical record documentation is required.

****continued on page 3; please complete and sign page 6 for prior authorization request****

Botulinum Toxin Injection – *continued*

7. Does the patient have a diagnosis of **spasticity**?..... ☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Is the patient 2 years of age or older?..... ☐ Yes ☐ No
   b. Does the patient have any of the following spastic conditions:
      i. Upper and/or lower limb spasticity?..... ☐ Yes ☐ No
      ii. Cerebral palsy?..... ☐ Yes ☐ No
      iii. Spasticity related to stroke?..... ☐ Yes ☐ No
      iv. Acquired spinal cord or brain injury?..... ☐ Yes ☐ No
      v. Hereditary spastic paraparesis?..... ☐ Yes ☐ No
      vi. Spastic hemiplegia?..... ☐ Yes ☐ No
      vii. Neuromyelitis optica?..... ☐ Yes ☐ No
      viii. Multiple sclerosis or Schilder's disease?..... ☐ Yes ☐ No
   c. Does the patient's spasticity result in functional impairment (interference with joint function, mobility, communication, nutritional intake) with or without pain?..... ☐ Yes ☐ No
   d. Is the request for Botox, Daxxify, or Myobloc?..... ☐ Yes ☐ No
      If YES, please answer the following questions:
      i. Has the patient tried and had an inadequate response with Xeomin?..... ☐ Yes ☐ No
         If YES, medical record documentation is required.
      ii. Has the patient tried and had an inadequate response with Dysport?..... ☐ Yes ☐ No
         If YES, medical record documentation is required.
      iii. Does the patient have a clinical contraindication or intolerance to BOTH Xeomin AND Dysport?..... ☐ Yes ☐ No
         If YES, medical record documentation is required.

8. Does the patient have a diagnosis of **chronic anal fissure**?..... ☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Is the patient 18 years of age or older?..... ☐ Yes ☐ No
   b. Has the patient tried and had an inadequate response to **ONE** of the following conventional therapies: topical nitrates or topical calcium channel blockers (e.g., diltiazem, nifedipine)? ☐ Yes ☐ No
   c. Does the patient have documented clinical contraindication or intolerance to **ALL** topical nitrates and topical calcium channel blockers?..... ☐ Yes ☐ No

9. Does the patient have a diagnosis of **esophageal achalasia**?..... ☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Has the patient failed dilation therapy?..... ☐ Yes ☐ No
   b. Is the patient considered a poor surgical candidate?..... ☐ Yes ☐ No

10. Does the patient have a diagnosis of **Hirschsprung disease**?..... ☐ Yes ☐ No
    a. **If YES,** did the patient develop obstructive symptoms after a pull-through operation?..... ☐ Yes ☐ No

****continued on page 4; please complete and sign page 6 for prior authorization request****

Botulinum Toxin Injection – *continued*

11. Does the patient have a diagnosis of **chronic migraine headache**?.....☐ Yes ☐ No
    If YES, please answer the following questions:
    a. Is the patient 18 years of age or older?.....☐ Yes ☐ No
    b. Has the patient had ≥ 15 headache days per month for a minimum of 3 months?.....☐ Yes ☐ No
    c. Has the patient had ≥ 8 migraine headache days per month for a minimum of 3 months?...☐ Yes ☐ No
    d. Is the patient using the requested agent for chronic migraine prophylaxis?.....☐ Yes ☐ No
    e. Has the patient been evaluated for and ruled out medication overuse headache?.....☐ Yes ☐ No
    f. Has the patient had an adequate trial (at least 6 weeks at generally accepted doses with ≥ 80% adherence) and had an inadequate response to any of the following migraine prophylaxis classes:
        i. Anticonvulsants (i.e., divalproex, valproate, topiramate)?.....☐ Yes ☐ No
        ii. Beta-blockers (i.e., atenolol, metoprolol, nadolol, propranolol, timolol)?.....☐ Yes ☐ No
        iii. Antidepressants (i.e., amitriptyline, venlafaxine)?.....☐ Yes ☐ No
        iv. Calcitonin gene-related peptide (CGRP) receptor antagonists (i.e., fremanezumab, galcanezumab, erenumab, eptinezumab)?.....☐ Yes ☐ No
    g. Does the patient have a documented clinical contraindication or intolerance to **ALL** anticonvulsants, beta blockers, antidepressants, and prophylactic CGRP antagonists?.....☐ Yes ☐ No
    h. Will the patient be using the requested medication in combination with a prophylactic CGRP antagonist for migraine prophylaxis?.....☐ Yes ☐ No
    If YES, please answer the following questions:
        i. Has the patient continued to experience 4 or more migraine headache days per month after treatment with at least a 6-month trial (2 injection cycles) with a botulinum toxin agent?.....☐ Yes ☐ No
        If YES, please submit medical record documentation.
        ii. Has the patient continued to experience 4 or more migraine headache days per month after treatment with at least a 3-month trial with a CGRP antagonist?.....☐ Yes ☐ No
        If YES, please submit medical record documentation.
    i. Is the request for Botox?.....☐ Yes ☐ No
    If YES, please answer the following questions:
        i. Has the patient tried and had an inadequate response to at least **ONE** CGRP antagonist for chronic migraine headache prophylaxis (e.g., fremanezumab, galcanezumab, erenumab, or eptinezumab)?.....☐ Yes ☐ No
        If YES, please submit medical record documentation.
        ii. Does the patient have a documented clinical contraindication or intolerance to **ALL** CGRP antagonists?.....☐ Yes ☐ No
        If YES, please submit medical record documentation.

12. Does the patient have a diagnosis of **overactive bladder**?.....☐ Yes ☐ No
    If YES, please answer the following questions:
    a. Is the patient 18 years of age or older?.....☐ Yes ☐ No
    b. Does the patient have symptoms of urge urinary incontinence, urgency, and frequency?...☐ Yes ☐ No
    c. Has the patient tried and had an inadequate response to **ONE** anticholinergic agent (e.g., oxybutynin, tolterodine, trospium, solifenacin, etc.)?.....☐ Yes ☐ No
    d. Has the patient tried and had an inadequate response to a beta-3 adrenergic agonist (e.g., Myrbetriq [mirabegron])?.....☐ Yes ☐ No
    e. Does the patient have a documented clinical contraindication or intolerance to **ALL** anticholinergic agents AND beta-3 adrenergic agonists?.....☐ Yes ☐ No

****continued on page 5; please complete and sign page 6 for prior authorization request****

Botulinum Toxin Injection – *continued*

13. Does the patient have a diagnosis of **urinary incontinence** with detrusor muscle overactivity associated with neurogenic causes (e.g., spinal cord injury, multiple sclerosis)?..... ☐ Yes ☐ No
    If YES, please answer the following questions:
    a. Is the patient 18 years of age or older?..... ☐ Yes ☐ No
    b. Has the patient tried and had an inadequate response to **ONE** anticholinergic agent (e.g., oxybutynin, tolterodine, trospium, solifenacin, etc.)?..... ☐ Yes ☐ No
    c. Has the patient tried and had an inadequate response to a beta-3 adrenergic agonist (e.g., Myrbetriq [mirabegron])?..... ☐ Yes ☐ No
    d. Does the patient have a documented clinical contraindication or intolerance to **ALL** anticholinergic agents AND beta-3 adrenergic agonists?..... ☐ Yes ☐ No

14. Does the patient have a diagnosis of **neurogenic detrusor overactivity** (NDO)?..... ☐ Yes ☐ No
    If YES, please answer the following questions:
    a. Is the patient 5 years of age or older?..... ☐ Yes ☐ No
    b. Has the patient tried and had an inadequate response to **ONE** anticholinergic agent (e.g., oxybutynin, solifenacin, etc.)?..... ☐ Yes ☐ No
    c. Does the patient have a clinical contraindication or intolerance to **ALL** anticholinergic agents?..... ☐ Yes ☐ No

15. Does the patient have a diagnosis of **sialorrhea** (drooling)?..... ☐ Yes ☐ No
    If YES, please answer the following questions:
    a. Is the patient 18 years of age or older?..... ☐ Yes ☐ No
    b. Is the request for Xeomin?..... ☐ Yes ☐ No
        i. **If YES,** is the patient 2 years of age or older?..... ☐ Yes ☐ No
    c. Is the patient's diagnosis associated with a neurological disorder (e.g., amyotrophic lateral sclerosis, atypical parkinsonian disorders, cerebral palsy, Parkinson disease, stroke, traumatic brain injury)?..... ☐ Yes ☐ No
    d. Has the patient experienced excessive salivation for ≥3 months?..... ☐ Yes ☐ No
    e. Has the patient tried and had an inadequate response to at least 2 months continuous treatment with at least **ONE** conventional agent (e.g., anticholinergics, benztropine, oral hyoscyamine, glycopyrrolate)?..... ☐ Yes ☐ No
    f. Does the patient have a clinical contraindication or intolerance to **ALL** conventional agents?..... ☐ Yes ☐ No
    g. Is the request for Botox, Daxxify, or Myobloc?..... ☐ Yes ☐ No
    If YES, please answer the following questions:
        i. Has the patient tried and had an inadequate response with Xeomin?..... ☐ Yes ☐ No
        If YES, medical record documentation required.
        ii. Does the patient have a clinical contraindication or intolerance to Xeomin?..... ☐ Yes ☐ No
        If YES, medical record documentation required.

16. Does the patient have a diagnosis of **strabismus**?..... ☐ Yes ☐ No
    a. **If YES,** is the patient 12 years of age or older?..... ☐ Yes ☐ No

****continued on page 6; please complete and sign page 6 for prior authorization request****

Botulinum Toxin Injection – *continued*

17. Does the patient have a diagnosis of **severe primary axillary or palmar hyperhidrosis**?.....☐ Yes ☐ No
    If YES, please answer the following questions:
    a. Is the patient 18 years of age or older?.....☐ Yes ☐ No
    b. Does the patient have focal, visible, excessive sweating of at least 6 months duration without apparent cause?.....☐ Yes ☐ No
    c. Does the patient have any of the following characteristics of excessive sweating:
        i. Bilateral and relatively symmetric sweating?.....☐ Yes ☐ No
        ii. Impairment of daily activities?.....☐ Yes ☐ No
        iii. Frequency of at least one episode per week?.....☐ Yes ☐ No
        iv. Age of onset is less than 25 years?.....☐ Yes ☐ No
        v. Positive family history?.....☐ Yes ☐ No
        vi. Cessation of focal sweating during sleep?.....☐ Yes ☐ No
    d. Does the patient have any of the following associated medical conditions:
        i. Acrocyanosis of the hands?.....☐ Yes ☐ No
        ii. History of recurrent skin maceration with bacterial or fungal infections?.....☐ Yes ☐ No
        iii. History of recurrent secondary infections?.....☐ Yes ☐ No
        iv. History of persistent eczematous dermatitis despite medical treatments with topical dermatologic or systemic anticholinergic agents?.....☐ Yes ☐ No
    e. Does the patient's hyperhidrosis cause function impairment (e.g., inability to perform activities of daily living and/or manual tasks in a professional setting)?.....☐ Yes ☐ No
    f. Have potential causes of secondary hyperhidrosis been ruled out (e.g., hyperthyroidism)? ☐ Yes ☐ No
    g. Has the patient tried and had an inadequate response with topical medications (e.g., aluminum chloride 20% solution)?.....☐ Yes ☐ No
    h. Does the patient have a documented clinical contraindication or intolerance to **ALL** topical medications?.....☐ Yes ☐ No

18. Will the patient be using the requested medication for another FDA approved indication?.....☐ Yes ☐ No
    If YES, please indicate condition: _____
    Medical records and references/evidence must be provided in order for this request to be processed.

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-888-348-7332

BlueCross BlueShield of North Carolina

Botulinum Toxin Injection – CONTINUATION

abobotulinumtoxinA (Dysport®), incobotulinumtoxinA (Xeomin®), onabotulinumtoxinA (Botox®), rimabotulinumtoxinB (Myobloc®), daxibotulinumtoxinA-lanm (Daxxify™)

FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PRIOR REVIEW/CERTIFICATION REQUEST FOR SERVICES FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, or NPI #**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #			

PLACE OF SERVICE: ☐ Home Infusion ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE:	**CPT/Other billing code:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

Please select the requested medication and answer the following questions for <u>CONTINUATION</u> coverage:

☐ Botox – J0585 ☐ Dysport – J0586 ☐ Xeomin – J0588
☐ Daxxify – J0589 ☐ Myobloc – J0587

1. Will the requested agent be used for cosmetic purposes (e.g., glabellar lines, wrinkles)?.....☐ Yes ☐ No

2. Was the patient approved for initial coverage for the requested medication through Blue Cross NC and is continuing therapy for one of the initial coverage indications?.....☐ Yes ☐ No
   If NO, please answer all questions on pages 1-6. If YES, please answer the following questions:

3. Has the patient had a positive clinical response to botulinum toxin therapy?.....☐ Yes ☐ No

4. Will the patient be receiving botulinum toxin more frequently than every 12 weeks?.....☐ Yes ☐ No

****continued on page 8; please complete and sign page 8 for prior authorization request****

Botulinum Toxin Injection - *continued*

5. Does the patient have a diagnosis of **chronic migraine headache**?.....☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Has the patient's migraine headache frequency been reduced by at least 7 days per month compared to pre-treatment frequency?.....☐ Yes ☐ No
   b. Has the patient's migraine headache duration been reduced by at least 100 hours per month compared to pre-treatment duration?.....☐ Yes ☐ No
   c. Will the patient be using the requested medication in combination with a prophylactic CGRP antagonist for migraine prophylaxis?.....☐ Yes ☐ No
      If YES, please answer the following questions:
      i. Has the patient continued to experience 4 or more migraine headache days per month after treatment with at least a 6-month trial (2 injection cycles) with a botulinum toxin agent?.....☐ Yes ☐ No
         If YES, please submit medical record documentation.
      ii. Has the patient continued to experience 4 or more migraine headache days per month after treatment with at least a 3-month trial with a CGRP antagonist?.....☐ Yes ☐ No
         If YES, please submit medical record documentation.

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

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