OKLAHOMA Health Care Authority

State of Oklahoma SoonerCare
Botulinum Toxins Prior Authorization Form

SoonerSelect | aetna

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

Drug Information

Dose:_____ ***Frequency:***_____ ***Start Date:***_____

HCPCS Code:_____ ***Billing Units Per Dose:***_____ ***J.W. Units:***_____

CPT Code:_____ ***Member's Weight:***_____

Billing Provider Information

Provider NPI:_____ ***Provider Name:***_____

Provider Phone:_____ ***Provider Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Clinical Information

Page 1 of 2—Please complete and return all pages. Failure to complete all pages will result in processing delays.

Diagnosis:_____ *(Diagnosis is required for all Botulinum Toxins)*

Please note: Botox® and Dysport® are the preferred products for SoonerCare

Chronic Migraine: Please complete the following section. (Only Botox® will be approved for this indication.)

1. 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☐
2. 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☐
3. Does member have any contraindications to Botox injections? Yes☐ No☐
4. Number of headache days per month?_____
5. Number of migraine days per month?_____
   a. How long has the member had chronic migraines at the frequency listed above?_____ months
6. What is the average duration of migraines?_____ hours
7. Has the member failed at least 2 different types of medications typically used for migraine prevention [e.g., select antihypertensives (such as beta-blockers), select anticonvulsants (such as valproate or topiramate), select antidepressants (such as amitriptyline or venlafaxine)]? Yes☐ No☐ If yes, please list:
   Medication_____ Date Span_____ Dosing_____
   Medication_____ Date Span_____ Dosing_____
   a. If the trial duration for the medication(s) listed above is not a least 8 weeks, please document the reason(s):
   Medication(s)_____
   Reason(s) for discontinuation prior to 8 weeks:_____
8. 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. Decongestants (alone or in combination products)? Yes☐ No☐
   b. Combination analgesics containing caffeine and/or butalbital? Yes☐ No☐
   c. Opioid-containing medications? Yes☐ No☐
   d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs)? Yes☐ No☐
   e. Ergotamine-containing medications? Yes☐ No☐
   f. Triptans? Yes☐ No☐
9. If member is taking any of the medication(s) listed in Question 8, please list the medication(s) and the number of days per month taken:_____

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma.	

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

Clinical Information

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

Chronic Migraine, Continued:

10. If member is taking any of the medication(s) listed in Question 8 (page 1), please provide additional information to support member's need for continued use of medication(s) known to cause overuse or rebound headaches:
    _____
11. Is the member taking any medications that are likely to be the cause of the headaches? Yes☐ No☐
12. 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:_____
13. If applicable, are other aggravating factors that contribute to the development of episodic/chronic migraine headaches being treated (e.g., smoking)? Yes☐ No☐ NA☐
14. Will member use botulinum toxin concurrently with a calcitonin gene-related peptide (CGRP) inhibitor for the prevention of migraine? Yes☐ No☐

Neurogenic Detrusor Overactivity (NDO): Please complete the following section.
(Only Botox® will be approved for this indication.)

1. Is the member 18 years of age or older with urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury, multiple sclerosis]? Yes☐ No☐
2. Is the member a child (5 to 17 years of age) with NDO? Yes☐ No☐
3. Have urodynamic studies been performed? Yes☐ No☐ If yes, include date_____
4. Based on the urodynamic studies, what is the specific underlying pathological urologic dysfunction (e.g., small bladder capacity <400 cc, high detrusor pressure, etc)?_____
5. Does member keep diary of fluid intake,voiding/catheterization times and amounts or number of diapers/pads used daily to provide a record of occurrences? Yes☐ No☐
6. Please provide a clinically significant reason why anticholinergic medications are no longer an option for the member:
   _____
7. Does the member have the physical and cognitive ability to self-catheterize or have a caregiver who is able to catheterize the member when necessary? Yes☐ No☐
8. Was the medication prescribed by a urologist? Yes☐ No☐

Non-Neurogenic Overactive Bladder: Please complete the following section.
(Only Botox® will be approved for this indication.)

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 specific pathology for this diagnosis been determined via urodynamic studies? Yes☐ No☐
4. Has member participated in behavioral therapy? Yes☐ No☐
   If yes, please give length of therapy and reason for therapy failure:_____
   _____
5. Has member used at least 3 anti-muscarinic or beta-3 adrenoceptor agonist 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_____
6. Does the member have the physical and cognitive ability to self-catheterize or a caregiver who is able to catheterize the member when necessary? Yes☐ No☐
7. Was the medication prescribed by a urologist? Yes☐ No☐

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.

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