

BOTOX, MYOBLOC, DYSPORT AND XEOMIN

Prior Authorization Form

IF THIS IS URGENT REQUEST, Please call the UPMC Health Plan Pharmacy Services,
Otherwise Please return the completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

THIS SECTION FOR PROVIDER USE ONLY—PLEASE TYPE OR PRINT NEATLY

Incomplete responses may delay this request.

Office Contact:	Provider Specialty:
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Provider First Name:	Provider Last Name:
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Provider Phone:	Provider Fax:	Provider NPI #:
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Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
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Drug Requested: <input type="checkbox"/> Brand <input type="checkbox"/> Generic	Strength:	Frequency:	Qty Dispensed:
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Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<input type="checkbox"/> New Medication	If Ongoing Provide Date Started:	If medication is ongoing, did the member show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing Medication	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic	Will the drug be: (select one)	<input type="checkbox"/> No

Please indicate place of administration:	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic	Will the drug be: (select one) <input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient
Please provide hospital/facility name and address:		

Please indicate the diagnosis on the left and complete the corresponding questions.

<input type="checkbox"/> Hyperhidrosis	Has the member tried and failed 10-20% topical aluminum chloride?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the prescribing physician a dermatologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Migraine Headache	Does the member have headaches occurring on 15 or more days a month for at least 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are 8 or more of the total headache days per month considered migraine or probable migraine days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does the member have greater than 4 distinct headache episodes each lasting greater than 4 hours a day or longer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is the member using opioids for greater than 10 days per month?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other (Please Specify) _____

History of other Medications Used To Treat The Above Condition

(Specific clinical information is essential to determine whether this medication can be approved)

Medication Trial/ Previous Therapy	Date of Therapy Start Date End Date	Strength	Frequency	List Adverse Reactions/Side Effects/ Reason For Discontinuing

Please provide any additional information which should be considered in the space below:
