UPMC Health Plan

BOTOX, MYOBLOC, DYSPORT, AND XEOMIN

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, please call 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

PLEASE TYPE OR PRINT NEATLY.

Please complete all sections of this form AND include details of past relevant medical treatment that substantiates the need for an exception to using formulary alternatives (e.g., past prescription treatment failures, documented side effects, chart documentation, lab values, etc.). Incomplete responses may delay this request.

Office Contact:	**Provider Specialty:**	
Provider First Name:	**Provider Last Name:**	
Provider Phone:	**Provider Fax:**	**Provider NPI #:**

Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**

Drug Requested: ☐ **Brand** ☐ **Generic**	**Strength:**	**Frequency:**	**Qty. Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐ **New Medication** ☐ **Ongoing Medication**	**If ongoing, provide date started:**	**If medication is ongoing, did the member show improvement while on therapy?**	☐ **Yes** ☐ **No**
Please indicate place of administration:	☐ Physician Office ☐ Hospital/Clinic ☐ Patient Home	**Will the drug be: (select one)** ☐ Billed directly by the provider via JCODE JCODE: _____ ☐ Billed by a pharmacy and delivered to the provider ☐ 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.

☐ Hyperhidrosis	Has the member tried and failed 10-20% topical aluminum chloride?	☐Yes ☐No
	Is the prescribing physician a dermatologist?	☐Yes ☐No
☐ Migraine Headache	Does the member have headaches occurring on 15 or more days a month for at least 3 months?	☐Yes ☐No
	Are 8 or more of the total headache days per month considered migraine or probable migraine days?	☐Yes ☐No
	Does the member have greater than 4 distinct headache episodes, each lasting 4 hours a day or longer?	☐Yes ☐No
	Is the member using opioids for greater than 10 days per month?	☐Yes ☐No
☐ Overactive Bladder (with urgency, urge incontinence, and frequency)	Is the prescribing physician a urologist or fellowship-trained urogynecologist?	☐Yes ☐No
	Have there been greater than 3 urinary urgency incontinence episodes in a 3-day period?	☐Yes ☐No
	Have there been greater than 8 micturitions per day?	☐Yes ☐No
	Has the member tried and failed behavioral therapy (such as weight loss, dietary changes, exercise)?	☐Yes ☐No
	Please provide chart documentation showing specific examples of how quality of life is impacted.	☐Included ☐Not available
☐ 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	Date of Therapy End Date	Strength	Frequency	List Adverse Reactions/Side Effects/ Reason For Discontinuing

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