CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Botulinum Toxin Type A and B
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION
*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI** Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code and description): ☐ _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has a diagnosis of **Strabismus, Achalasia**, or **Chronic Anal Fissures**? ☐ Yes ☐ No
- Patient has one of the following disorders associated with spasticity or Dystonia? ☐ Yes ☐ No

☐ Blepharospasm
☐ Hereditary Spastic Paraplegia
☐ Multiple Sclerosis
☐ Schilder's Disease
☐ Spasticity form Stroke or Spinal Cord Injury
☐ Idiopathic Torsion Dystonia
☐ Orofacial Dyskinesia (i.e., jaw closure dystonia)
☐ Symptomatic Torsion Dystonia
☐ Cervical Dystonia
☐ Equinus foot, if related to Cerebral Palsy
☐ Infantile Cerebral Palsy
☐ Neuromyelitis Optica
☐ Spastic Hemiplegia
☐ Upper Limb spasticity
☐ Organic Writer's Cramp
☐ Spasmodic Dysphonia/Laryngeal Dystonia*
☐ Facial Nerve (VII) Dystonia
☐ Forms of Upper Motor Neuron Spasticity

- Patient has drooling (sialorrhea) associated with Parkinson's disease. ☐ Yes ☐ No
- Patient has Cervical Dystonia? *(If Yes, please answer #1-6 below)* ☐ Yes ☐ No

1 - Prior to the initiation of therapy, was the cervical dystonia moderate in severity or greater? ☐ Yes ☐ No
2 - Does the patient have a history of recurrent clonic and/or tonic involuntary contractions in the sternocleidomastoid, splenius, trapezius, or posterior cervical muscles? ☐Y ☐N
3 - Prior to the initiation of therapy, did the patient exhibit sustained head tilt and/or abnormal posturing with limited range of motion in the neck? ☐ Yes ☐ No
4 - Is the duration of cervical dystonia greater than 6 months? ☐ Yes ☐ No
5 - Has the patient previously received botulinum toxin? ☐ Yes ☐ No
6 – If Yes, Did the patient respond to the initial treatment and was this response documented in the medical record? ☐ Yes ☐ No

- Patient has incontinence related to bladder/detrusor overactivity or incontinence of neurogenic origin? ☐ Yes ☐ No
  - Patient has an inadequate response to anticholinergic therapy? ☐ Yes ☐ No
- Patient has bladder/detrusor sphincter dyssynergia of neurogenic orgin? ☐ Yes ☐ No
- Patient has hyperhidrosis that is incapacitating or causing persistent chronic cutaneous conditions? ☐ Yes ☐ No
- Patient has had an inadequate response to a 6-month trial of non-surgical treatment for hyperhidrosis? ☐ Yes ☐ No

* A disorder of speech due to abnormal control of the laryngeal muscles present only during the specific task of speaking.

****NOTES:** Botulinum Toxin is **not approvable** for the following, as well as other conditions:

- Skin Wrinkles or other cosmetic indications
- Headache, except for prevention of chronic migraine
- Anismus
- Chronic Motortic Disorder
- Fibromyalgia/Fibromyositis
- Gastroparesis
- Low Back Pain
- Myofacial Pain Syndrome
- Neck Pain not related to conditions mentioned above
- Parkinson's Disease
- Tics associated with Tourette's Syndrome
- Tourette's Syndrome
- Tremors
- Urinary and Anal Spinchter Dysfunction
- Stuttering
- Carpal Tunnel Syndrome

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For chronic migraine, physicians requesting initial therapy or renewals are required to provide information from the headache diary or other evidence of the patient's headache frequency and duration*

- Does the patient experience headache on ≥ 15 days per month? ☐ Yes ☐ No
- Do headaches last ≥ 4 hours? ☐ Yes ☐ No
- Please document the patient's pre-treatment monthly headache frequency and daily headache duration.
- Has the patient experienced headaches for ≥ 3 months? ☐ Yes ☐ No
- Has the patient been evaluated for medication overuse headache and treated as appropriate? ☐ Yes ☐ No
- Did the patient complete adequate trials (each ≥ 8 weeks) of at least 2 oral preventative agents from different pharmacological classes? ☐ Yes ☐ No
- Please document oral preventative agents tried.

a.	Divalproex sodium	☐ Yes ☐ No
b.	Topiramate	☐ Yes ☐ No
c.	Gabapentin	☐ Yes ☐ No
d.	Amitriptyline	☐ Yes ☐ No
e.	Venlafaxine	☐ Yes ☐ No
f.	Fluoxetine	☐ Yes ☐ No
g.	Propranolol, timolol, atenolol, metoprolol, or nadolol	☐ Yes ☐ No
h.	Nimodipine, verapamil or diltiazem	☐ Yes ☐ No
i.	Lisinopril	☐ Yes ☐ No
j.	Candesartan	☐ Yes ☐ No
k.	Other (please document)	☐ Yes ☐ No

- If patient has not tried 2 oral agents, does the patient have a contraindication to each pharmacological class of agents not tried? ☐ Yes ☐ No
- If not contraindicated, is there another clinical reason(s) for not completing adequate trials of all pharmacological classes? ☐ Yes ☐ No
- Please document the agent(s) tried and the reason(s) for discontinuation.

a.	Allergic reaction	☐ Yes ☐ No
b.	Adverse event	☐ Yes ☐ No
c.	Unable to tolerate medication/unpleasant side effect	☐ Yes ☐ No
d.	Significant drug interaction	☐ Yes ☐ No
e.	Other (please document below)	☐ Yes ☐ No

_____

- If patient is receiving botulinum toxin therapy, how many days per month has the headache frequency decreased since starting therapy? _____
- If patient is receiving botulinum toxin therapy, how many hours per month has the headache duration decreased since starting therapy? _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Botox				
☐ Dysport				
☐ Myobloc				
☐ Xeomin				

X _____ X _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)