Prior Authorization Form

Dysport

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.

Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Dysport.

Drug Name (select from list of drugs shown)

Dysport (abobotulinumtoxinA) Other, Please specify

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is Botox, Dysport, or Xeomin being prescribed for cosmetic purposes? (e.g., treatment of Y N

wrinkles)	
[If yes, then no further questions.]	
2. Does the patient have any of the following contraindications to the use of Botox, Dysport, or Xeomin?	Y N
-Hypersensitivity to any botulinum toxin preparation or any components of the formulation	
-Infection at the proposed injection site(s)	
-Allergy to cow's milk protein (for those considered for treatment with Dysport)	
[If yes, then no further questions.]	
3. Will the patient be monitored for life-threatening symptoms of spread of toxin effect from the injection site (e.g., breathing and swallowing difficulties)?	Y N
[If no, then no further questions.]	
4. Does the patient have a diagnosis of chronic migraine?	Y N
[If no, then skip to question 11.]	
5. Is the patient currently receiving botulinum toxin type A (BTX-A) therapy through a CVS Caremark administered benefit?	Y N
[If yes, then skip to question 10.]	
6. Does the patient experience15 or more headache days per month?	Y N
[If no, then no further questions.]	
7. Do the headaches last 4 or more hours?	Y N
[If no, then no further questions.]	
8. Has the patient completed an adequate trial (8 or more weeks) of oral migraine preventative therapy (e.g., beta-blocker [propranolol], antiepileptic drug [topiramate], antidepressant [amitriptyline])?	Y N
[If yes, then no further questions.]	
9. Was the patient unable to tolerate oral migraine preventative therapy or does the patient have a contraindication to oral migraine preventative	Y N

therapy?	
[No further questions.]	
10. Has the patient achieved or maintained a 50% reduction in monthly headache frequency since starting BTX-A therapy?	Y N
[No further questions.]	
11. Does the patient have a diagnosis of blepharospasm?	Y N
[If no, then skip to question 14.]	
12. Is the request for Xeomin?	Y N
[If no, then no further questions.]	
13. Has the patient received previous treatment with Botox?	Y N
[No further questions.]	
14. Does the patient have a diagnosis of strabismus?	Y N
[If yes, then no further questions.]	
15. Does the patient have a diagnosis of cervical dystonia (e.g., torticollis)?	Y N
[If yes, then no further questions.]	
16. Does the patient have a diagnosis of chronic anal fissures?	Y N
[If yes, then no further questions.]	
17. Is therapy requested for the treatment of achalasia in a patient who is a poor candidate for endoscopic dilation or surgery?	Y N
[If yes, then no further questions.]	
18. Does the patient have a diagnosis of primary axillary hyperhidrosis?	Y N
[If no, then may skip to question 20.]	
19. Has the patient tried conventional treatments, such as topical aluminum chloride solution or iontophoresis, without adequate relief?	Y N
[No further questions required.]	
20. Does the patient have a diagnosis of sphincter of Oddi dysfunction?	Y N

[If yes, then no further questions.]	
21. Does the patient have a diagnosis of excessive salivation secondary to advanced Parkinson's disease?	Y N
[If yes, then no further questions.]	
22. Does the patient have a diagnosis of dysphagia?	Y N
[If yes, then no further questions.]	
23. Is the patient experiencing spasticity in the upper or lower limbs due to cerebral palsy, multiple sclerosis, stroke, or post-traumatic brain or spinal cord injury?	Y N
[If yes, then no further questions.]	
24. Does the patient have detrusor sphincter dyssynergia due to a spinal cord injury?	Y N
[If yes, then no further questions.]	
25. Does the patient have a diagnosis of overactive neurogenic bladder dysfunction?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date