PreferredOne®

Botulinum Toxin (Botox, Dysport, Myobloc, & Xeomin) for Headache Syndromes

Please follow-up with PreferredOne Customer Service (800.997.1750 Option #3) for Approval/Denial status of this request.

Attn: Pharmacy Dept. Fax (763.847.4014) **All fields required. Incomplete and/or Incorrect forms will be returned.**

MEMBER INFORMATION

MEMBER NAME:			
MEMBER ID:	DATE OF BIRTH:	GENDER: ☐ M ☐ F ☐ O	
ADDRESS:	CITY:	STATE:	ZIP:

PROVIDER INFORMATION

PROVIDER NAME: *(FIRST & LAST)*		NPI NUMBER:	SPECIALTY:
CLINIC NAME:	CONTACT: *(NAME & PHONE)*	SECURE FAX/EMAIL:	
ADDRESS:	CITY:	STATE:	ZIP:

MEDICATION REQUESTED

☐ INITIAL REQUEST ☐ RENEWAL REQUEST	DRUG NAME AND STRENGTH:	DIAGNOSIS (ICD-10):
DOSING REQUESTED:	THERAPY START DATE:	THERAPY START DATE:

IS THE PATIENT CURRENTLY BEING TREATED WITH REQUESTED DRUG? ☐ YES ☐ NO
IF YES, PLEASE INDICATE DATE TREATMENT BEGAN:

PLEASE LIST ALL OTHER MEDICATIONS THE PATIENT WILL BE TAKING IN COMBINATION WITH THE REQUESTED MEDICATION FOR THIS DIAGNOSIS:

INITIAL REVIEW

DOES THE PATIENT HAVE A DIAGNOSIS OF CHRONIC, INTRACTABLE MIGRAINE HEADACHES (WITH OR WITHOUT AURA) OCCURRING 8 OR MORE DAYS A MONTH OR CHRONIC DAILY HEADACHE DEFINED AS MEMBERS EXPERIENCING MORE THAN 15 DAYS OF HEADACHE PER MONTH? ☐ YES ☐ NO
HEADACHES PER MONTH: MIGRAINES DAYS PER MONTH:

DOES THE PATIENT HAVE DOCUMENTED ATTEMPTS AT FORMAL BEHAVIORAL OR PHYSICAL THERAPY TREATMENT? (SELECT ALL THAT APPLY)

☐ HOME EXERCISE PROGRAM ☐ MASSAGE ☐ PHYSICAL THERAPY ☐ OCCUPATIONAL THERAPY ☐ ACUPUNCTURE ☐ MEDITATION
☐ OTHER:

DOES THE MEMBER HAVE A HISTORY OF TRIAL AND FAILURE (AFTER AT LEAST A TWO-MONTH TRIAL) OF THE FOLLOWING PROPHYLACTIC MEDICATIONS? (SELECT ALL THAT APPLY; AT LEAST 3 REQUIRED)

☐ ELAVIL (AMITRIPTYLINE) ☐ ATENOLOL ☐ EFFEXOR (VENLAFAXINE) ☐ PROPRANOLOL ☐ DEPAKOTE/DEPAKOTE ER (DIVALPROEX SODIUM)
☐ NADOLOL ☐ TOPAMAX (TOPIRAMATE) ☐ TIMOLOL ☐ PAMELOR (NORTRIPTYLINE) ☐ METOPROLOL
☐ OTHER:

RENEWAL REVIEW

IS THERE DOCUMENTATION SUPPORTING AT LEAST ONE OF THE FOLLOWING? PLEASE SELECT ALL THAT APPLY

☐ DECREASE IN MEDICATION USE ☐ DECREASE IN EMERGENCY ROOM VISITS ☐ DECREASE IN MISSED DAYS AT WORK
☐ DECREASED PAIN FREQUENCY AND SEVERITY ☐ INCREASED ACTIVITIES ☐ DOCUMENTED IMPROVEMENT IN SYMPTOMS

Please note that this, and other PreferredOne prescription prior authorization requests, can be completed online at **PreferredOne.com/providers**. For assistance locating these forms, please reach out to PreferredOne Customer Service at 800.997.1750 Option #3.