Updated: 06/2025
Approved: 06/2025

Request for Prior Authorization for Botulinum Toxins Name
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Botulinum Toxins require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Botulinum Toxins Prior Authorization Criteria:

For all requests the following criteria must be met in addition to the diagnosis specific criteria below:

- Must be prescribed for an FDA-approved or medically accepted indication
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines

Coverage may be provided with a diagnosis of **chronic migraine** as prophylaxis and the following criteria is met:

- The member has at least 15 headache days per month for at least 3 months with headache lasting at least four hours per day
- Must provide documentation showing the member has tried and failed for at least 2 months (at optimal or maximum tolerated dose) or had an intolerance or contraindication to at least three migraine prophylaxis agents (e.g., topiramate, propranolol, metoprolol, divalproex, sodium valproate)
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria:**
- Documentation of clinical benefit and tolerance to therapy.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

HIGHMARK HEALTH OPTIONS

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BOTULINUM TOXINS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

For chronic migraine prophylaxis:

- Does the member have headaches occurring on 15 or more days a month for at least 3 months? ☐ Yes ☐ No
- Do the headaches last at least 4 hours per day? ☐ Yes ☐ No
- Has the member tried 3 migraine prophylaxis agents? ☐ Yes, please list below ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Is there documentation of clinical benefit and tolerance to therapy? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date