South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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PIERRE, SD 57501-22941

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BOTULINUM TOXIN PRIOR AUTHORIZATION REQUEST FORM

Use this form when therapy is requested for axillary hyperhidrosis
This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Quantity:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
***Note:** The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA			
☐	**Medical records to support use of product are submitted**		
Initial Therapy (check one)		**Yes** ☐	**No** ☐
☐	Therapy is for onabotulinumtoxinA (Botox)		
☐	Individual has a diagnosis of primary axillary hyperhidrosis		
☐	Therapy is prescribed by a specialist in dermatology or another appropriate specialist		
☐	Potential causes of secondary hyperhidrosis have been ruled out (ex. hyperthyroidism)		
☐	The condition is causing persistent or chronic cutaneous conditions (e.g., skin maceration, dermatitis, fungal infections, secondary microbial infections)		
☐	Documentation is provided indicating that the condition is causing significant functional impairment leading to disruption of daily activities		
☐	Documentation is provided indicating failure of (for ≥2 month trial), intolerance or contraindication to topical agents (ex. ≥20% aluminum chloride)		
☐	Individual is ≥18 years of age		
Continuation of Therapy (check one)		**Yes** ☐	**No** ☐
☐	Individual continues to meet initial criteria		
☐	Documentation is submitted indicating a positive response to therapy		
PHYSICIAN SIGNATURE – PROVIDER ONLY			
This form must be signed by a physician			
☐	I certify that the information given in this form is a true and accurate medical indication for the required product		
Name & Title (Printed):		**Specialty:**	
Signature:			