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 WEB: [DSS Medicaid Prior Authorizations](#) | EMAIL : DSSMedicaidpa@state.sd.us

BOTULINUM TOXIN PRIOR AUTHORIZATION REQUEST FORM

Use this form when therapy is requested for blepharospasm
 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:		Dose & Frequency:
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	Phone:	Fax:
<small><i>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.</i></small>		
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) or incobotulinumtoxinA (Xeomin)	
	Individual has a diagnosis of blepharospasm	
	Therapy is prescribed by or in consultation with a neurologist or ophthalmologist	
	Individual has symptoms consistent with all the following: <ul style="list-style-type: none"> • Bilateral involuntary intermittent or sustained eyelid closure • Symptoms are progressively worsening or persistent and cause disruption to daily tasks • Symptoms are not relieved by other measures such as stress reducing techniques, lifestyle changes such as good nutrition, exercise, adequate sleep and/or decreased caffeine intake 	
	Individual is ≥12 years of age for Botox, ≥18 years of age for Xeomin	
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 <u>must be</u> signed by a provider		
	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:		