



PHONE: 605-773-3495 | FAX: 605-773-5246  
WEB: [DSS Medicaid Prior Authorizations](#) | EMAIL : [DSSMedicaidpa@state.sd.us](mailto:DSSMedicaidpa@state.sd.us)

## BOTULINUM TOXIN PRIOR AUTHORIZATION REQUEST FORM

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

Date:		
<b>RECEIPIENT INFORMATION</b>		
Medicaid ID:	Date of Birth:	Sex:    M        F
Last Name:	First Name:	
<b>GENERAL INFORMATION</b>		
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:		
<b>POINT OF CONTACT</b>		
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>		
<b>REFERRING PROVIDER INFORMATION</b>		
Name:		
NPI #:	Taxonomy:	
Phone:	Fax:	
<b>SERVICING PROVIDER INFORMATION</b>		
Name:		
Address:		
NPI #:	Taxonomy:	
Phone:	Fax:	

<b>CRITERIA</b>		
<b>Medical records to support use of product are submitted</b>		
<b>Initial Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
	Therapy is for onabotulinumtoxinA (Botox), abobotulinumtoxinA (Dysport), incobotulinumtoxinA (Xeomin), rimabotulinumtoxinB (Myobloc) or daxibotulinumtoxinA (Daxxify)	
	Individual has a diagnosis of cervical dystonia	
	Therapy is prescribed by or in consultation with specialist in neurology, physical medicine rehab, pain management or another appropriate specialist	
	Documentation is provided indicating that the individual has one more involuntary muscle contractions in the neck (sternocleidomastoid, splenius capitis, splenius cervicis, scalene complex, semispinalis capitis, trapezius, longissimus, levator scapulae)	
	Individual has sustained head torsion and/or tilt causing limited range of motion in the neck, pain in the neck, and/or functional impairment	
	Individual is $\geq 18$ years of age for Dysport, Myobloc, Xeomin and Daxxify, $\geq 16$ years of age for Botox	
<b>Continuation of Therapy (check one)</b>	<b>Yes</b>	<b>No</b>
	Individual continues to meet initial criteria	
	Documentation is submitted indicating a positive response to therapy	
<b>PHYSICIAN SIGNATURE – PROVIDER ONLY</b>		
This form <u>must be</u> signed by a physician		
	I certify that the information given in this form is a true and accurate medical indication for the required product	
<b>Name &amp; Title (Printed):</b>		<b>Specialty:</b>
<b>Signature:</b>		