South Dakota Department of Social Services

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

PHONE: 605-773-3495 | FAX: 605-773-5246
WEB: DSS Medicaid Prior Authorizations | **EMAIL :** 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:		
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), 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		
☐	The product is administered via electromyography (EMG) guided injections		
☐	Individual is ≥ 18 years of age for Dysport, Myobloc, Xeomin and Daxxify, ≥16 years of age for Botox		
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:			