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 overactive bladder
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)		
☐	Therapy is prescribed by or in consultation with a specialist in neurology, urology, urogynecology or another appropriate specialist		
☐	Individual has a diagnosis of **one** of the following: ☐ Overactive bladder with symptoms of urinary incontinence, urgency or frequency ☐ Urinary incontinence associated with a neurologic condition (ex. multiple sclerosis, spinal cord injury, CVA, etc.)		
☐	Individual meets one of the following in regards to age and indication for requested therapy ☐ Overactive bladder: individual is ≥18 years of age ☐ Neurologic involvement: individual is ≥5 years of age		
☐	Documentation is provided indicating a failure of (≥2 month therapy), intolerance or contraindication to one oral anticholinergic medication and one oral beta-3 agonist medication		
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:			