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

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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 sialorrhea
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 rimabotulinumtoxinB (Myobloc) or incobotulinumtoxinA (Xeomin)	
	Therapy is prescribed by a specialist in endocrinology, neurology, otolaryngology or another appropriate specialist	
	Individual is ≥2 years of age for Xeomin, ≥18 years of age for Myobloc	
	Sialorrhea has been present for 3+ months and has resulted from **one** of the following • Underlying neurologic disorder (Parkinson's disease, stroke, traumatic brain injury, intellectual disability, genetic/congenital disorder, cerebral palsy, etc.) • Craniofacial abnormality	
	Documentation is provided indicating failure (≥3 months), intolerance or contraindication to **one** of the following: • Glycopyrrolate • Scopolamine	
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:		