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## 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:		
<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 rimabotulinumtoxinB (Myobloc) or incobotulinumtoxinA (Xeomin)	
	Therapy is prescribed by a specialist in endocrinology, neurology, otolaryngology or another appropriate specialist	
	Individual is $\geq 2$ years of age for Xeomin, $\geq 18$ years of age for Myobloc	
	Sialorrhea has been present for 3+ months and has resulted from <b>one</b> of the following <ul style="list-style-type: none"> <li>• Underlying neurologic disorder (Parkinson's disease, stroke, traumatic brain injury, intellectual disability, genetic/congenital disorder, cerebral palsy, etc.)</li> <li>• Craniofacial abnormality</li> </ul>	
	Documentation is provided indicating failure ( $\geq 3$ months), intolerance or contraindication to <b>one</b> of the following: <ul style="list-style-type: none"> <li>• Glycopyrrolate</li> <li>• Scopolamine</li> </ul>	
<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>		