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 spasticity
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:	**Dose & Frequency:**	
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 prescribed by or in consultation with a specialist in pain management, neurology, physical medicine/rehab or another appropriate specialist	
☐	Treatment is utilizing the corresponding approved agents based on location of limb spasticity: • Upper extremity: onabotulinumtoxinA (Botox), abobotulinumtoxinA (Dysport), or incobotulinumtoxinA (Xeomin) • Lower extremity: onabotulinumtoxinA (Botox) or abobotulinumtoxinA (Dysport)	
☐	Limb spasticity is related to **at least one** of the following: ☐ Cerebral palsy (excluded by incobotulinumtoxinA) ☐ Multiple sclerosis ☐ Spinal cord injury ☐ Traumatic brain injury ☐ Stroke ☐ Hereditary spastic paraplegia	
☐	Documentation is submitted indicating the location of patient's spasticity (upper and/or lower extremity) and supporting evidence that symptoms are causing a significant decrease or alteration in function or activities of daily living	
☐	Individual meets the following age requirements with corresponding drug agent: • Botox: age ≥2 years • Dysport: age ≥2 years • Xeomin: age ≥2 years (for upper limb only)	
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:		