Print Reset

Alaska Medicaid

Botox® Prior Authorization Form

This form may also be used for requests to exceed the maximum allowed units.
Form available on Alaska Medicaid's Medication Prior Authorization website

Physician providers from office supply (J-Code billing): fax this form to HMS at **(907) 644-8131**. Procedure codes, date of service, and ICD-10 fields are required for physician providers.

Pharmacy providers (drug to be dispensed from pharmacy): fax this form to **(888) 603-7696**. Incomplete requests will be denied until all required information is received.

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

Request Date: _____

REQUESTOR INFORMATION

Requestor Name: _____ Title: _____

MEMBER INFORMATION

Last Name: _____ First Name: _____

Member ID #: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Member Phone: _____

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

Group ID: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

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Last Name: _____ First Name: _____

DRUG INFORMATION

Drug Name: _____ NDC: _____

Drug Strength: _____ Dosage Form: _____

Dosage Schedule: _____ Quantity: _____ Day Supply: _____

Procedure Code: _____ Date of Service: _____

Is this a physician-administered drug? ☐ Yes ☐ No

CLINICAL INFORMATION

1. Primary diagnosis: _____
2. ICD-10 Code: _____
3. How old is the member? ☐ < 12 years old ☐ 12–17 years old ☐ ≥ 18 years old
4. The member is being treated for which of the following?
   - ☐ Cervical Dystonia
   - ☐ Severe Axillary Hyperhidrosis
   - ☐ Upper Limb Spasticity
   - ☐ Blepharospasm *(answer question 5)*
   - ☐ Strabismus
   - ☐ Chronic Migraines *(answer question 6)*
   - ☐ Other: _____
5. If the member is being treated for **blepharospasm**, answer the following:
   a. Is the member unable to open eyelid(s) or functionally blind due to dystonia?
      ☐ Yes ☐ No
   b. Are you the ordering neurologist or ophthalmologist?
      ☐ Yes ☐ No *If NO, submit the plan of care/chart notes from the ordering MD.*
6. If the patient is being treated for **chronic migraines**, answer the following:
   a. Does the patient have headaches ≥ 15 days per month?
      ☐ Yes ☐ No
   b. Is the patient on a medication regimen for migraine prophylaxis?
      ☐ Yes ☐ No *If YES, list the regimen:* _____
   c. Are you the ordering neurologist?
      ☐ Yes ☐ No *If NO, submit the plan of care/chart notes from the ordering MD.*

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Last Name: _____ First Name: _____

☐ Attachments

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Alaska Medicaid.

Prescriber Signature: _____ **Date:** _____
(required)

Magellan Medicaid Administration, PA Unit
14100 Magellan Plaza
Maryland Heights, MO 63043
Phone: (800) 331-4475

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