PRESCRIBER'S STATEMENT OF MEDICAL NECESSITY

Prior-Authorization –Botox (botulinum toxin type A) or Myobloc (botulinum toxin type B)

Maryland Pharmacy Program, Division of Pharmacy Services

Tel#: 410-767-1455 or 1-800-492-5231 Option 3

Fax form to: 410-333-5398 (Incomplete forms will be returned)

Patient Information

Patient location: ☐ home ☐ hospital ☐ Nursing Home- Injection to be given at ☐ Office ☐ Clinic ☐ Nursing Home ☐ Hospital

Patient Name:_____ Address: _____

MA ID#:_____ _____

Tel.#: (_____) _____-_____ Body Weight_____kg or_____lb Birthdate_____Sex: M____F___

Prescription Information

RX- Circle : Botox Myobloc

Dispense: # vials: _____ Units per vial: _____

Sig: _____Repeat every_____ months.

Anticipated length of therapy: _____

Request for: ☐ Initiation of therapy ☐ Continuation of therapy

Scheduled injection date:_____/_____/_____

List other therapies tried:_____

_____

Please answer all questions:

1. Indications for which Botox/Myobloc has been prescribed:
   _____
2. Number of units to be injected per injection site:_____
3. Number of sites to be injected:_____
4. Specific sites of injection:_____
5. Frequency of injections (no more than once every 90 days recommended):_____
6. Specify off-label use*, if applicable: _____
   _____

   * Cosmetic use of Botox/Myobloc will **not** be approved. All other unlabelled uses must be safe and medically necessary. Evidence of clinical benefits must be demonsstrated and supported by peer-reviewed literature and any one of the three official compendia, the American Hospital Formulary Service, the U.S.P. Pharmacopeia Drug Information, or the Micromedex Drugdex database.

Clinical Prior Authorization is required and will be granted per treatment due to possible changes in dosage and injection sites. A separate Prior-Auth Request form is required to be completed every 3 months. Prescribers may not bill the Botox under Physicians Services if medication is paid under Pharmacy Services.

I certify that this treatment is medically necessary. I will be supervising the treatment accordingly. Supporting medical documentation is available in the patient record.

_____**, M.D.** **Prescriber's Name**:_____

Prescriber's signature Date:_____ Address: _____

Tel# (_____) – _____- _____Fax#(_____) - _____ - _____ _____

Pharmacy Information

Pharmacy: _____

Phone # (_____)_____ Fax # (_____) _____-_____

Claims submitted on-line will deny for service prior-authorization. Pharmacists are to call the State at 410-767-1755 or 1-800-492-5231, Option 3 for an override for each Botox/Myobloc prescription. Enter a 90-day supply for each prescription.

_____-

Prior-Auth Determination: ☐ **Approved** **Date**_____

☐ **Denied**_____**Reason**_____

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