

APPLIES TO COMMERCIAL AND MEDICAID

**Health New England
Medication Request Form (MRF) /Prescription Request
Botox® (onabotulinum toxin type A)- Myobloc® (rimabotulinum toxin type B)**

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

Prior Authorization Only

Prior Authorization and Drug Delivery Request

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Botox®. Please complete this form and fax to ICORE Healthcare at (866)-364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

Medication Request Information (please complete each section of this form prior to transmittal):

J-code: Botox J0585 1 unit
 Myobloc J0587 100 units

Patient Information (all required)		Physician Information (all required)	
Patient Name:		Physician Name:	
Patient Cell Phone #: () -		Specialty:	
Patient HNE ID#:		NPI #:	
Patient Date of Birth:		HNE Provider #:	
Allergies:		DEA # (required):	
		Telephone #: () -	
		Fax # : () -	

Drug Information			
Requested Drug/Strength/Form: Botox® Myobloc®			
Dose, Directions, and length of treatment (please be specific):		Quantity (per month):	Refills:
Physician Signature:		Date:	

Initial Authorization Criteria

- What is the diagnosis (*required*): _____
 - If hyperhidrosis, what treatment options have been tried? _____
 - If esophageal achalasia, what treatment options have been tried? _____
 - If migraine, cervicogenic or tension type headache: at least three (3) prophylactic AND three (3) abortive agents must have been attempted. Please list drugs: _____
- For Blepharospasm (*required*) - Is physician aware cumulative dose of Botox treatment in a 30-day period is not to exceed 200 units: YES NO

Renewal Authorization Criteria

- What is diagnosis (*required*): _____
- For Blepharospasm (*required*): Is physician aware cumulative dose of Botox treatment in a 30-day period is not to exceed 200 units? YES NO
- Does physician have documentation of improvement in the condition for which the patient initially sought treatment? (*required*) YES NO