

Health New England
Medication Request Form (MRF) /Prescription Request
Botox® (botulinum toxin type A)- Myobloc® (botulinum 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:
	Specialty:
Patient Cell Phone #: () -	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA # (required):
Allergies:	Telephone #: () -
	Fax # : () -

Drug Information

Requested Drug/Strength/Form: Botox® Myobloc®

Dose, Directions, and length of treatment (please be specific):	Quantity (per month):	Refills:
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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