Date _____

RESTAT
PRESCRIPTION BENEFIT MANAGERS

Client _____

PRIOR AUTH QUESTIONNAIRE- BOTOX®/MYOBLOC

M.D. Last Name: _____ ***M.D. First Name:*** _____

Physician Phone: _____ ***Physician Fax:*** _____

Patient _____ ***ID#*** _____ ***DOB*** _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

PLEASE NOTE: ***FOR ALL REQUESTS, PLEASE ATTACH THE MOST RECENT COPY OF THE PATIENT'S PROGRESS NOTES***

1. Drug Requested: ☐ **Botox** ☐ **Myobloc**

2. Please choose the diagnosis
   - ☐ Cervical dystonia in adults to decrease the severity of abnormal head position and neck pain (**Both Botox and Myobloc**)
   - ☐ Axilliary hyperhidrosis (**Botox Only**)
   - ☐ Strabismus and blepharospasm associated with dystonia, age 12 and older (**Botox Only**)
   - ☐ Other diagnosis: _____
     Note: If Other diagnosis is used, please attach a study with efficacy data supporting this request

3. Does the patient have an infection at the site of injection? Yes No

4. Is the patient being treated for wrinkles or any other cosmetic indication? Yes No

5. Is the patient being treated for treatment of restrictive strabismus, Duane's syndrome with lateral rectus weakness or secondary strabismus caused by surgical over-recession of the antagonist? Yes No

6. Is the patient being treated for any of the following investigational uses? Yes No
   - ☐ headache or migraine
   - ☐ myofacial pain syndrome
   - ☐ tremors such as benign essential tremor
   - ☐ chronic motor tic
   - ☐ tics associated with Tourette syndrome

7. **FOR RENEWALS:** Has this member demonstrated symptomatic improvement in health related quality of life? Yes No

Approval Period: ***If member qualifies for use, BOTOX or MYOBLOC approval will be granted for 6 months.***
Renewal Period: ***If member continues to qualify for use, approval will be granted for additional 6 month periods.***

Physician Signature or name of person providing answers _____

Physician Comments _____

_____

_____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095
www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906