62004

KANSAS MEDICAID
PRIOR AUTHORIZATION

OnabotulinumtoxinA (Botox®)
AbobotulinumtoxinA (Dysport®)
RimabotulinumtoxinB (Myobloc®)
IncobotulinumtoxinA (Xeomin®)

Request Date __ / __ / ____

BENEFICIARY INFORMATION

Beneficiary Medicaid ID Number

Beneficiary Date of Birth __ / __ / ____

Beneficiary Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City **State** **Zip Code** -

Prescriber Phone: - -

Prescriber Fax: - -

Prescriber Medicaid ID #

Prescriber NPI #

NDC Requested:

Strength _____ **Quantity** _____ **Length of Therapy on Prescription** _____

OR - Procedure Code requested: _____ **Total # of units requested per 6 months:** _____

Prescription instructions(sig):_____

Please indicate the diagnosis for which Botulinum Toxin is being prescribed (no dx codes) and designate location for treatment:

_____

_____

_____

Have any other Botulinum Toxins been tried? If so, list product and diagnosis being treated:

_____

PLEASE NOTE: DOCUMENTATION MAY BE REQUIRED FOR SOME DIAGNOSIS.
NOT APPROVED FOR COSMETIC PURPOSES.

Signature of Prescriber_____ __ / __ / ____
Date

***Prescriber signature mandatory**

FAX TO: KANSAS Medicaid Prior Authorizations
Fax: (866) 246-8512
PA HELPDESK: (877) 475 - 7567

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August 2011