



Kansas Medical Assistance Program
P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

**OnabotulinumtoxinA (Botox®)
AbobotulinumtoxinA (Dysport®)
RimabotulinumtoxinB (Myobloc®)
IncobotulinumtoxinA (Xeomin®)
Prior Authorization Request Form**

Beneficiary Information

Beneficiary Name: _____

Beneficiary Medicaid ID #: _____ Date of Birth: ___/___/___

Billing Provider Information (Physician OR Facility)

Billing Provider's Name: _____

Provider Medicaid ID#: _____ Provider NPI#: _____

Phone Number: (____) _____ Fax Number: (____) _____

Procedure Code Requesting: _____ Total # of Units Requested (per 6 months): _____

Prescriber Information

Prescriber's Name: _____

Prescriber's Medicaid ID#: _____ Prescriber's NPI#: _____

Phone Number: (____) _____ Fax Number: (____) _____

Requested Information

1. Please indicate the diagnosis for which botulinum toxin is being prescribed and indicate location for treatment (no diagnosis codes): _____

2. Has another botulinum toxin been used in the past?

Yes _____ No _____

3. If the answer to the above question is 'Yes', please list product used and diagnosis treated:

ADDITIONAL DOCUMENTATION MAY BE REQUIRED FOR SOME DIAGNOSES

NOTE: Botulinum Toxins will not be approved for cosmetic purposes.

Prescriber's Signature: _____ Date: ___/___/___

**Completed form should be faxed to the Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**