Chorus Community Health Plans
PO Box 1997 - MS 6280 | Milwaukee, WI 53201-1997
Toll-free: 1-844-201-4672 | chorushealthplans.org

Prior Authorization Form: Botulinum Toxin

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services. Otherwise, please return completed form- Phone: 844-201-4677

Please complete all sections of this form and include details of past relevant medical treatment that substantiates the need for an exception to using formulary alternatives (e.g. past prescription treatment failures, documented side effects, chart documentation, lab values, etc.) Incomplete response may delay the request.

Office Contact:		Provider Specialty:
Provider First Name:		Provider Last Name:
Provider Phone:		Provider Fax:
Provider NPI:		Patient Name:
Together with CCHP ID Number:		Patient DOB:
Patient Age:		Drug Requested: ☐ Brand ☐ Generic
Strength:	Frequency	Qty. Dispensed:
Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.		
☐ New medication ☐ Ongoing Medication	If ongoing, provide date started:	If medication is ongoing, did the memb show improvement while on therapy? ☐Yes ☐No
Please indicate place of administration:	☐Physician Office ☐Hospital / Clinic ☐Patient Home	Will the drug be: (select one) ☐Billed directly by the provider via JCode ☐Billed by a pharmacy delivered to the provider ☐Billed by a pharmacy and delivered to the patient
Please provide hospital / facility name and address:		

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Please indicate the diagnosis on the left and complete the corresponding questions.	
☐Hyperhidrosis: Has the member tried and failed 10-20% topical aluminum chloride? Is the prescribing physician a dermatologist?	☐Yes ☐No ☐Yes ☐No