Outpatient Medical Injectables
Treatment of Hyperhidrosis Request Form
Fax to 833-619-5745
(Medical Benefit Only)

Member Name:_____

Member Date of Birth:_____

Member UMI:_____

Requesting Physician's Name:_____NPI Number: _____

Requesting Physician's Address:_____

Office Contact:_____Phone #:_____Fax #:_____

Facility:_____Facility NPI Number:_____

Facility's Address:_____

Date of Service:_____

Diagnosis Code(s):_____

S-78 Treatment of Hyperhidrosis
1. Please confirm which product this request is for (select one): **Botox J0585 / Myobloc J0587**
2. Please confirm if this is a **new therapy** for the patient or a **continuation of care** (where the patient is a Highmark member who has a previous authorization on file or has been treated with the above medication(s) but has recently changed to Highmark Insurance: • New Therapy Yes / No o Please complete questions 3 through 5. • Continuation of care Yes / No o Please complete question 6. **Please attach all pertinent clinical information** **Attached: Yes / No**

****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-619-5745

This information is issued on behalf of Highmark Blue Shield and its affiliated Blue companies, which are independent licensees of the Blue Cross Blue Shield Association. Highmark Inc. d/b/a Highmark Blue Shield and certain of its affiliated Blue companies serve Blue Shield members in 21 counties in central Pennsylvania and 13 counties in northeastern New York. As a partner in joint operating agreements, Highmark Blue Shield also provides services in conjunction with a separate health plan in southeastern Pennsylvania. Highmark Inc. or certain of its affiliated Blue companies also serve Blue Cross Blue Shield members in 29 counties in western Pennsylvania, 13 counties in northeastern Pennsylvania, the state of West Virginia plus Washington County, Ohio, the state of Delaware and 8 counties in western New York. All references to Highmark in this document are references to Highmark Inc. d/b/a Highmark Blue Shield and/or to one or more of its affiliated Blue companies.

3. Please answer all of the following general necessary criteria related to the treatment of primary focal hyperhidrosis:

- Has the patient experienced any of the following: Yes / No
  - Acrocyanosis of the hands
  - History of recurrent skin maceration with bacterial or fungal infections
  - History of atopic dermatitis in spite of medical treatments with topical dermatological or systemic anticholinergic agents
- Has the patient been unresponsive to or unable to tolerate pharmacotherapy modalities prescribed for excessive sweating? (including but not limited to anticholinergics, beta-blockers, or benzodiazepines) Yes / No
- Has the patient used topical 20% aluminum chloride or other extra strength antiperspirants that were either ineffective or resulted in a severe rash? Yes / No

4. Please indicate which focal region the Botulinum Toxin will be treating: **(circle one)**

Axillary Region / Palmar Region / Plantar Region / Craniofacial Region / Secondary Hyperhidrosis: Secondary Gustatory Hyperhidrosis

5. Please answer the following necessary policy criteria:

- Is the patient's primary hyperhidrosis considered severe and inadequately managed with topical agents? Yes / No
- Will the Botulinum Toxin be used for Iontophoresis Yes / No
- Will the Botulinum Toxin be used for Endoscopic transthoracic sympathectomy (ETS) if conservative treatment has failed? Yes / No
- Will the Botulinum Toxin be used as a surgical option (e.g., tympanic neurectomy) if conservative treatment has failed? Yes / No

6. Please answer the following related to Botulinum Toxin used as a continuation of care for the patient:

Primary Axillary Hyperhidrosis:

- Since starting botox has the patient experienced clinical improvement of the condition by an objective measurable effect? Yes / No
  - Please state the objective measure which has demonstrated clinical improvement: _____

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Any other indication:

- Please list which diagnosis the Botulinum Toxin is being continued for _____
- Has the patient seen improvement or stability in their condition? Yes / No

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