**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.10(2), Wis. Admin. Code

F-00701 (08/2019)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ONABOTULINUMTOXINA (BOTOX®)**

**TO TREAT CHRONIC MIGRAINES**

**Instructions:** Type or print clearly. Before completing this form, refer to the Prior Authorization Drug Attachment for OnabotulinumtoxinA (Botox®) to Treat Chronic Migraines Completion Instructions, F-00701A.

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| **SECTION I — MEMBER AND PROVIDER INFORMATION** | | | |
| 1. Name — Member (Last, First, Middle Initial) | | | |
| 2. Member Identification Number | | 3. Date of Birth — Member | |
| 4. Name — Rendering Provider | | 5. National Provider Identifier (NPI) — Rendering Provider | |
| 6. Address — Rendering Provider (Street, City, State, ZIP+4 Code) | | | |
| 7. Telephone Number — Rendering Provider | | | |
| 8. Name — Billing Provider | | 9. NPI — Billing Provider | |
| **SECTION II — DRUG ORDER INFORMATION** | | | |
| 10. Drug Name  OnabotulinumtoxinA (Botox®) | 11. HCPCS Drug Code  J0585 | | 12. Treatment Dose (In Units) |
| 13. Frequency of Treatments | | 14. Units to Be Billed Per Treatment | |
| **SECTION III — CLINICAL INFORMATION FOR BOTOX® — INITIAL REQUEST ONLY** | | | |
| 15. Is the member 18 years of age or older?  Yes  No | | | |
| 16. Has the rendering provider evaluated the member and diagnosed the member as experiencing  chronic migraines using the Revised International Headache Society criteria for chronic migraines?  Yes  No | | | |
| 17. Has the member experienced headaches (tension-type and/or migraine) for **three or more**  months that have lasted **four or more** hours per day on **15 or more** days per month, with **eight  or more** headache days per month being migraines / probable migraines (and that are not due  to medication overuse or attributed to another causative disorder)?  Yes  No | | | |
| 18. Did the member score a grade indicating moderate to severe disability on the Migraine Disability Assessment (MIDAS) test or on a similar validated tool?  Yes  No | | | |
| 19. Has the rendering provider discussed alternative nonpharmacological treatment options with the  member, such as behavioral therapies, physical therapies, and lifestyle modifications?  Yes  No | | | |

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| **SECTION III — CLINICAL INFORMATION FOR BOTOX® — INITIAL REQUEST ONLY (Continued)** |
| 20. Check the boxes next to the drug categories from which the member has tried migraine prophylaxis medications. In the space provided, document the following:   * The names of the medications tried. * The approximate dates the medications were received. * Specific details about the treatment results, including if the medications resulted in an unsatisfactory therapeutic response or a clinically significant adverse drug reaction.   1. Antidepressants  2. Anticonvulsants  3. Beta blockers  4. Calcium channel blockers  5. Other drugs  Has the member tried migraine prophylaxis medications from **three or more** of the drug categories listed above?  Yes  No  If not, does the member have a medical condition that prevents him or her from trying migraine  prophylaxis medications from **three or more** of the drug categories listed above, or is there  a clinically significant drug interaction with a medication the member is currently taking that  prevents him or her from trying migraine prophylaxis medications from **three or more** of the  drug categories listed above?  Yes  No  Document specific details about the member’s medical condition or the clinically significant drug interaction. |

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| **SECTION IV — CLINICAL INFORMATION FOR BOTOX® — FIRST RENEWAL REQUEST ONLY (Following Initial Approval Only)** | |
| 21. Has the member experienced clinically significant and documented improvement in the  frequency or duration of chronic migraines using at least **one** of the indicators below?  Yes  No  If yes, check all that apply.  Reduction in acute services, emergency services, or need for rescue treatment for acute chronic migraines.  At least a 40 percent reduction in the frequency, severity, or length of chronic migraines.  Improved assessment score on MIDAS test, or on similar validated tool.  Reduced use of analgesics.  If no, explain the medical necessity for further treatment. | |
| **SECTION V — CLINICAL INFORMATION FOR BOTOX® — SUBSEQUENT RENEWAL REQUESTS ONLY (Following First Renewal Approval Only)** | |
| 22. Does the member **continue to experience** the previously documented clinically significant  improvement in the frequency or duration of chronic migraines as a result of Botox® treatment?  Yes  No  If no, explain the medical necessity for further treatment. | |
| **SECTION VI — ATTESTATION AND AUTHORIZED SIGNATURE** | |
| 23. **SIGNATURE** — Rendering Provider | 24. Date Signed — Rendering Provider |
| **SECTION VII — ADDITIONAL INFORMATION** | |
| 25. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here. | |