**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 NameOnabotulinumtoxinA (Botox®) | 11. HCPCS Drug CodeJ0585 | 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 MigraineDisability 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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**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ONABOTULINUMTOXINA (BOTOX®) TO TREAT CHRONIC MIGRAINES** Page 2 of 3

F-00701 (08/2019)

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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 drugcategories listed above? [ ]  Yes [ ]  NoIf 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 [ ]  NoDocument specific details about the member’s medical condition or the clinically significant drug interaction.       |

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**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ONABOTULINUMTOXINA (BOTOX®) TO TREAT CHRONIC MIGRAINES** Page 3 of 3

F-00701 (08/2019)

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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 [ ]  NoIf 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 [ ]  NoIf 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.       |