DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00701 (08/2019)

STATE OF WISCONSIN
DHS 107.10(2), Wis. Admin. Code

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.

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	11. HCPCS Drug Code	12. Treatment Dose (In Units)
OnabotulinumtoxinA (Botox®)	J0585	
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

Continued

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.

Continued

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.

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