FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ONABOTULINUMTOXINA (BOTOX®) TO TREAT CHRONIC MIGRAINES COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services. Providers are expected to be able to make available upon request clinical documentation supporting all information submitted on this form.

Rendering providers are required to use this form when requesting PA for OnabotulinumtoxinA (Botox®) to treat chronic migraines. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Rendering providers may submit PA requests on the Prior Authorization Drug Attachment for OnabotulinumtoxinA (Botox®) to Treat Chronic Migraines form, F-00701, in one of the following ways:

1) For requests submitted on the ForwardHealth Portal, rendering providers can access *www.forwardhealth.wi.gov/.*

2) For requests submitted by fax, rendering providers should submit a Prior Authorization Request Form (PA/RF), F-11018, and the Prior Authorization Drug Attachment for OnabotulinumtoxinA (Botox®) to Treat Chronic Migraines, F-00701, to ForwardHealth at (608) 221-8616.

3) For requests submitted by mail, rendering providers should send a PA/RF and the Prior Authorization Drug Attachment for OnabotulinumtoxinA (Botox®) to Treat Chronic Migraines form to the following address:

    ForwardHealth
    Prior Authorization
    Ste 88
    313 Blettner Blvd
    Madison WI 53784

Rendering providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — MEMBER AND PROVIDER INFORMATION

Element 1 — Name — Member
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters.

Element 3 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

Element 4 — Name — Rendering Provider
Enter the name of the rendering provider ordering the service for which PA is being requested.

Element 5 — National Provider Identifier (NPI) — Rendering Provider
Enter the rendering provider's 10-digit National Provider Identifier (NPI).

Element 6 — Address — Rendering Provider
Enter the address (street, city, state, and ZIP+4 code) of the rendering provider.

Element 7 — Telephone Number — Rendering Provider
Enter the telephone number, including area code, of the rendering provider.

Element 8 — Name — Billing Provider
Enter the name of the billing provider.

Element 9 — NPI — Billing Provider
Enter the billing provider's NPI.

SECTION II — DRUG ORDER INFORMATION

Element 10 — Drug Name
This element is populated with OnabotulinumtoxinA (Botox®).

Element 11 — HCPCS Drug Code
This element is populated with J0585.

Element 12 — Treatment Dose (In Units)
Enter the number of units of Botox® that will be administered per treatment.

Element 13 — Frequency of Treatments
Enter the frequency with which the member will receive Botox® treatments.

Element 14 — Units to Be Billed Per Treatment
Enter the number of units of Botox® that will be billed per treatment (the units administered plus the units wasted).

SECTIONS III, IV, or V

Rendering providers are required to complete *one* of Section III, IV, or V.

SECTION III — CLINICAL INFORMATION FOR BOTOX® — INITIAL REQUEST ONLY

Element 15
Indicate whether or not the member is 18 years of age or older.

Element 16
Indicate whether or not the rendering provider has evaluated the member and diagnosed the member as experiencing chronic migraines using the Revised International Headache Society criteria for chronic migraines.

Element 17
Indicate whether or not the member has 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).

Element 18
Indicate whether or not the member scored a grade indicating moderate to severe disability on the Migraine Disability Assessment (MIDAS) test or on a similar validated tool.

Element 19
Indicate whether or not the rendering provider has discussed alternative nonpharmacological treatment options with the member, such as behavioral therapies, physical therapies, and lifestyle modifications.

Element 20
Check the boxes next to the drug categories from which the member has tried migraine prophylaxis medications. In the space provided, document the names of the medications tried, the approximate dates the medications were received, and specific details about the treatment results, including if the medications resulted in an unsatisfactory therapeutic response or a clinically significant adverse drug reaction.

Indicate whether or not the member has tried migraine prophylaxis medications from **three or more** of the drug categories listed. If "no," indicate whether or not the member has a medical condition that prevents him or her from trying migraine prophylaxis medications from **three or more** of the drug categories listed, or indicate whether or not there is 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. Document specific details about the member's medical condition or the clinically significant drug interaction in the space provided.

SECTION IV — CLINICAL INFORMATION FOR BOTOX® — FIRST RENEWAL REQUEST ONLY (Following Initial Approval Only)
Complete this section for first renewal requests for Botox®, following approval of an initial PA request for Botox®.

Element 21
Indicate whether or not the member has experienced clinically significant and documented improvement in the frequency or duration of chronic migraines using at least **one** of the indicators listed. If "yes," check all of the indicators that apply. If "no," explain the medical necessity for further treatment.

SECTION V — CLINICAL INFORMATION FOR BOTOX® — SUBSEQUENT RENEWAL REQUEST ONLY (Following First Renewal Approval Only)
Complete this section for subsequent renewal requests for Botox®, following approval of a first renewal PA request for Botox®.

Element 22
Indicate whether or not the member **continues to experience** the previously documented clinically significant improvement in the frequency or duration of chronic migraines as a result of Botox® treatment. If "no," explain the medical necessity for further treatment.

SECTION VI — ATTESTATION AND AUTHORIZED SIGNATURE

Element 23 — Signature — Rendering Provider
The rendering provider is required to complete and sign this form.

Element 24 — Date Signed — Rendering Provider
Enter the month, day, and year the form was signed by the rendering provider in MM/DD/CCYY format.

SECTION VII — ADDITIONAL INFORMATION

Element 25
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the product requested may be included here.