Outpatient Medical Injectables Botulinum Toxin – Chemodenervation Request Form. Fax to 833-581-1861
(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):____

I-11 Chemodenervation – Botulinum Toxin
1. Please confirm which product this request is for **(select one):** Botox J0585 / Dysport J0586 / Xeomin J0588 / Myobloc J0587 **New Therapy:** If diagnosis is for prevention of chronic migraine headache in adults, please complete question 2. If diagnosis is for chemodenervation for a condition OTHER than chronic migraine, please complete question 3. **Continuation of care:** If this is a continuation request for a Highmark member who has a previous authorization on file, or has been treated with the above medications but has recently changed to Highmark insurance, please complete question 4. **Please attach all pertinent clinical information** **Attached: Yes / No**

2. Please answer all of the following for policy to be met for **Botox** to be used in chronic migraine headache:

- How many days a month does patient experience headache? ______
- When patient experiences migraines, how many hours a day do they last? ______
- For how long has patient been experiencing migraine headaches? ______
- Is this request prescribed by or in consultation with a neurologist or headache specialist? Yes / No
- Is a healthcare provider trained in administration of botox administering the drug? Yes / No
- Has the diagnosis of chronic migraine headache been established using the International Classification of Headache Disorders, Third Edition? (ICHD-III) Yes / No
- Has there been a persistent three month history of recrurring debilitating headache docuemnted by the patient via headache diary or calender? Yes / No
- Are the headaches caused by medication rebound or lifestyle issues? Yes / No
- Has the patient tried and failed adequate trials of prophylactic therapy from at least two different therapy classes? (please include names of medications failed): ____
    - Were the medications the patient failed prescribed at adequate doses for reasonable lengths of time? Yes / No

3. Please indicate which medically necessary condition Botulinum Toxin is intended to be used for:

- Diagnosis:____
- Please list any other medications or procedures the patient has tried and failed (if any) for the requested condition:____

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

Chronic Migraine Headache:

- Since starting botox has the patient's migraine headache frequency reduced by at least 50% from baseline? Yes / No
- Since starting botox has the patient's migraine headache hours reduced by at least 50% from baseline? Yes / No
- What percentage reduction in symptoms/migraine days has the patient experienced since starting botox? ________

Any other indication:

- Please list which diagnosis the Botulinum Toxin is being continued for __________________

Please fax this completed form to Highmark at 1-833-581-1861