Botulinum Toxin Prior Authorization form

☐ Initial Request
☐ Recertification Request

Request Date: _____

Patient Name:	Patient Id:
Procedure Date:	
Ordering Clinician Name:	Performing Clinician Name (If different from ordering MD):
Ordering Clinician Address:	Performing Clinician Address:
Ordering Clinician NPI:	Performing Clinician NPI:
Ordering Clinician phone number:	Performing Clinician phone number:
Contact Person:	Contact Person Phone Number:

Diagnosis code

☐ **G43.701** Chronic migraine without aura, not intractable, with status migrainosus

☐ **G43.709** Chronic migraine without aura, not intractable, without status migrainosus

☐ **G43.711** Chronic migraine without aura, intractable, with status migrainosus

☐ **G43.719** Chronic migraine without aura, intractable, without status migrainosus

☐ **Other** (include diagnosis code and description): _____

CPT Code for Procedure:

☐ **64615**

☐ **Other** (include CPT code): _____

Relevant Clinical information:

Total number of headaches days per month: _____

Duration of migraine attacks: _____

Number of migraine days per month: _____

Frequency of acute medication for treatment per month: _____

For recertification number of migraines pre-Botox vs post: _____

Prior treatments tried to date

Other medications tried for patient must have tried at least 1 from each of the following categories for at least 60 days (plan specific)

Drug Class	Drug Name
☐ Antidepressant ☐ Antiepileptic drug ☐ Antihypertensive	
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☐ Clinical documentation attached to support request