Washington State Health Care Authority

# Botulinum Toxin Request

Please answer the following questions and return the form as an attachment to your request. For a **first time** request or renewal of an authorization for botulinum toxin injections for incontinence due to overactive bladder or detrusor, sialorrhea, strabismus, or axillary hyperhidrosis **progress notes** are sufficient.

**However, Sections 1, 2, 3, and 4 on this page must be completed for all requests.**

## 1 Provider information

Name of provider

Provider NPI

Telephone number

Fax number

## 2 Client information

Name of client

ProviderOne Client ID

## 3 Service request information

Botulinum toxin procedure code

Number of botulinum toxin units requested for one treatment

Associated administration/chemodenervation codes requested for one treatment (such as 64642 and 98573), including units for each

## 4 Diagnosis information

Date of injury/illness

Place of service

Diagnosis code(s)

Diagnosis(es) description

## 5 Medical information

**Scenario 1 First time request for prior authorization for spasticity:** Complete this section for conditions such as spinal cord injury, TBI, CP, anoxic brain injury, dystonia (including blepharospasm), and CVA. If not a first-time request for prior authorization for these reasons, skip to the next scenario.

1. What functional goals do you have for this patient that will be enhanced by the use of botulinum toxin?

2. Has botulinum toxin been used before? ☐ Yes ☐ No

If yes, describe any functional benefits and explain why you think they are significant.

3. Is decreasing pain a treatment goal for bocnum toxin injections? ☐ Yes ☐ No

If yes, where is the pain, and why do you think that using botulinum toxin is medically necessary?

4. Are there hygiene issues? ☐ Yes ☐ No

If yes, why do you think that using botulinum toxin is medically necessary?

5. Are there caregiver issues? ☐ Yes ☐ No

If yes, why do you think that using botulinum toxin is medically necessary?

6. Are there positioning problems? ☐ Yes ☐ No

If yes, why do you think that using botulinum toxin is medically necessary?

7. What is the cause of this spasticity, eg., an upper neuron, dystonia?

8. Does the patient have a generalized increase in tone or is it focal? ☐ Generalized ☐ Focal

9. If surgery is an option, will it be delayed by botulinum toxin injections? ☐ Yes ☐ No

Are botulinum toxin injections a bridge to surgery? ☐ Yes ☐ No

10. Document ROM of affected joints (before and after botulinum toxin if it has been trialed already).

11. Do any of the areas you wish to inject have fixed contractures? ☐ Yes ☐ No

If yes, how would Botox help?

If no, will botulinum toxin injections forestall contractures?

12. Have therapies, splinting at night, or orthotics been tried? ☐ Yes ☐ No

If yes please describe the outcomes. If no, please explain why not.

13. Have medications such as baclofen been used? ☐ Yes ☐ No

If yes, please list medications tried. If medications have not been used, why not?

14. Has a baclofen pump been considered? ☐ Yes ☐ No

15. List specific muscles and units of botulinum toxin to be injected in each muscle.

16. What is your formula for determining the total dose of botulinum toxin for this patient?

17. For patients switching between Botox™ and Myobloc™ (or vice versa), how did you convert the units?

18. Is there an exit strategy for discontinuing botulinum toxin? ☐ Yes ☐ No

**Scenario 2 First time request for prior authorization for chronic migraine headaches:** This section must be completed. Clinical documentation is not a substitute for completion of this section . If not a first time request for prior authorization for this reason, skip to the next scenario.

1. Are you board certified in neurology? ☐ Yes ☐ No

**If not, this request must be signed off by a board-certified neurologist**

2. Are rebound headaches increasing the number of days per month the patient is experiencing headaches? ☐ Yes ☐ No

3. Rebound headaches notwithstanding, does the patient meet ICHD-II criteria for chronic migraines ( > 15 days per month, of which > 8 meet criteria for migraine without aura or respond to migraine specific treatment)? ☐ Yes ☐ No

4. What drug therapy classes have you used for preventative therapy and what benefit has been derived calcium channel blockers, beta blockers, anticonvulsants, antidepressants)?

5. What drug therapy classes for PRN treatment have you tried and what benefit was derived )ergotamines, NSAIDS, channel blockers, beta blockers, anticonvulsants, antidepressants)?

6. Has the patient had botulinum toxin injections for migraine in the past? ☐ Yes ☐ No

If yes, what were the results?

7. Will you be doing the botulinum toxin injections yourself? ☐ Yes ☐ No

If no, who will?

8. Are you willing to support the patient's use of a daily diary for 6 months following initiation of botulinum toxin injection and interpret the diary? ☐ Yes ☐ No

**Scenario 3 Renewal of previous authorization for spasticity:** Complete this section for conditions such as spinal cord injury, TBI, CP, anoxic brain injury, dystonia (including blepharospasm), and CVA. If not, skip to the next scenario.

1. What functional goals are met by using botulinum toxin injections?

2. If decreased pain is a treatment goal for botulinum toxin injections, please describe any benefits, including decreased use of pain medications, emergency room use, etc.

3. If hygiene is an issue, please describe any benefits from use of toxin.

4. If caregiving is an issue, describe any benefits.

5. If positioning is an issue, describe any benefits.

6. Is surgery able to be delayed by the use of toxin? ☐ Yes ☐ No

7. Document any pertinent changes in ROM.

Have contractures been avoided or lessened? ☐ Yes ☐ No

Have therapies been benefitted? ☐ Yes ☐ No

Has use of medication been avoided? ☐ Yes ☐ No

Have any exit strategies from using toxin been identified? ☐ Yes ☐ No

**Scenario 4 Renewal of a previous authorization for chronic migraines:** This section must be completed with information about positive effects from botulinum toxin treatment. Clinical documentation is not a substitute for completion of this section. Do not request authorization renewal until at least six weeks after the most recent botulinum toxin treatment.

Date of first botulinum toxin treatment

Date of most recent botulinum toxin treatment

1. Amounts of medications taken daily, including pain medication, sedatives, supplements and over-the-counter medications.

2. Frequency of headaches.

3. Severity of headaches and symptoms accompanying them.

4. Pain-related behaviors, such as isolation, missed social functions and/or work.

5. Duration of symptoms

6. Frequency of ER use and/or office visits.

**This is confidential information intended only for the person to whom it is faxed.**

Provider may submit authorization online direct data entry (**hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/prior-authorization-pa**) or fax this form along with the General Information for Authorization (GIA) form (13-835) to Authorization Services at 1-866-668-1214. The GIA form must be page one of your fax (no fax coversheet).