South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
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PIERRE, SD 57501-22941

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BOTULINUM TOXIN PRIOR AUTHORIZATION REQUEST FORM

Use this form when therapy is requested for migraine headaches
This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Dose & Frequency:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
***Note:** The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA

☐ **Medical records to support use of product are submitted**

Initial Therapy (check one) **Yes** ☐ **No** ☐

☐ Therapy is for onabotulinumtoxinA (Botox)

☐ Therapy is prescribed by (and administered) by a specialist in neurology, physical medicine rehab or pain specialist

☐ Individual has a diagnosis of chronic migraine meeting the following criteria as defined by the International Headache Society (IHS): 15 or more headache (migraine or tension type) days per month for at least 3 months, with headaches lasting ≥4 hours (with ≥8 consistent with migraine type)

☐ Documentation is provided indicating current headache days per month (with average duration of episode) as well as number of days per month requiring acute treatment

# of headache days/month: Average duration (hours): # of days/month requiring acute treatment:

☐ Individual is ≥18 years of age

☐ Documented failure of inadequate response (with a trial duration of ≥3 months), published contraindication, or intolerance to **at least three** different prescription migraine prevention therapies listed below (for migraine indication) from **at least two** of the medication classes. If disqualifying agents due to contraindications alone (without history of previous failed therapy), contraindications to all 5 classes listed below is required. Documentation must be submitted indicating reasoning behind each contraindication.

☐ Antidepressants
- ☐ Amitriptyline ☐ Nortriptyline

☐ Antiepileptic drugs
- ☐ Divalproex ☐ Gabapentin ☐ Topiramate ☐ Valproic acid

☐ Beta blockers
- ☐ Propranolol ☐ Atenolol ☐ Nadalol

☐ Calcium channel blockers
- ☐ Verapamil

☐ Calcitonin Gene-Related peptide (CGRP) antagonist
- ☐ Emgality ☐ Ajovy ☐ Aimovig ☐ Nurtec ☐ Quilpta ☐ Vyepti

☐ Documentation is supported in medical records that provider had addressed medication overuse (ex. opioids, barbiturates, chronic tylenol/ibuprofen, etc) as potential underlying migraine etiology

Continuation of Therapy (check one) **Yes** ☐ **No** ☐

☐ Individual continues to meet initial criteria

☐ Documentation is submitted indicating a decrease in the number of monthly migraine headache days or hours (additionally must provide current headache/migraine frequency for progress monitoring)

☐ Documentation is submitted indicating a decrease in the number of days requiring acute migraine treatment (additionally must provide current average use of acute treatment for progress monitoring)

# of headache days/month: Average duration (hours): # of days/month requiring acute treatment:

PHYSICIAN SIGNATURE – PROVIDER ONLY

This form must be signed by a physician

☐ I certify that the information given in this form is a true and accurate medical indication for the required product

Name & Title (Printed): **Specialty:**

Signature: