

(3) Cervical Dystonia (spasmodic torticollis)

For Initial Treatment (check all that apply)

- Individual diagnosed with cervical dystonia (spastic torticollis) of moderate or greater severity
- Individual has history of recurrent clonic or tonic involuntary contractions of one or more of the following muscles: sternocleidomastoid, splenius, trapezius, and/or posterior cervical muscles
- Individual has sustained head tilt or abnormal posturing with limited range of motion in the neck
- Condition persisted for greater than 6 months
- Other _____

For Subsequent Treatments (check all initial treatment criteria listed above and the following criteria that apply)

- Individual responded to the initial treatment (documented in the medical records)
- Individual still meets criteria listed under Initial Treatment
- Other _____

(4) Hyperhidrosis

- Individual diagnosed with primary hyperhidrosis
 - Individual has medical complications or skin maceration with secondary infection
 - Individual has significant functional impairment (documented in the medical records)
 - Individual failed a 6 month trial of non-surgical treatment
 - Please name failed non-surgical treatment** _____
 - Other _____
- Individual diagnosed with secondary hyperhidrosis related to surgical complications
 - Individual has significant functional impairment (documented in the medical records)

(5) Chronic Migraine Headaches

For Initial Treatment (check all that apply)

- Individual age 18 or older diagnosed with chronic migraine headache
- Individual has 15 or more migraine days per month with headache lasting 4 hours or longer
- First episode at least 6 months ago
- Symptoms persist despite trials of at least 1 agent in any 2 of the following classes of medications used to prevent migraines or reduce migraine frequency
 - Antidepressants (such as amitriptyline, nortriptyline, doxepin)
 - Please name failed medications** _____
 - Antihypertensives (such as propranolol, timolol)
 - Please name failed medications** _____
 - Antiepileptics (such as valproate, topiramate, gabapentin)
 - Please name failed medications** _____
- Other _____

For Subsequent Treatments (check all that apply)

- Individual age 18 or older diagnosed with chronic migraine headache
- Migraine headache frequency reduced by at least 7 days per month (when compared to pre-treatment average) by end of initial trial
- Migraine headache duration reduced by at least 100 total hours per month (when compared to pre-treatment average) by end of initial trial
- Other _____

(6) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name & Title of Provider or Provider Representative Completing Form
& attestation (Please Print)*

____ / ____ / ____
Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

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