Beneficiary Full Name: _____ Sponsor's SSN: _____-_____-_____

Date of Birth: _____ Beneficiary State of Residence: _____

Dear Provider,

Please complete the letter of attestation below and return as indicated on the additional information request letter.

Coverage for upper limb spasticity:

TRICARE Policy Manual, Chapter 7, Section 27.1, authorizes coverage of botulinum toxin A (Botox®) to treat spasticity in flexor muscles of the elbow, wrist and fingers (upper limb spasticity) in adults.

MEDICAL HISTORY

In order for botulinum toxin A to be approved for the treatment of patients with upper extremity spasticity, the provider must certify both of the following statements are true:

- ☐ The beneficiary has upper limb spasticity.
- ☐ Use of botulinum toxin A is requested to decrease the severity of increased muscle tone in elbow flexors (biceps) and/or wrist flexors (flexor carpi radialis and flexor carpi ulnaris) and/or finger flexors (flexor digitorum profundus and flexor digitorum sublimis).

Coverage for migraines:

TRICARE Policy Manual, Chapter 7, Section 27.1, authorizes coverage of botulinum toxin A (Botox®) for prophylaxis of headaches in adult patients with chronic migraine. Coverage is explicitly excluded for episodic migraine, chronic daily headache, cluster headache, cervicogenic headache, or tension-type headache.

MEDICAL HISTORY

In order for botulinum toxin A to be approved for the treatment of patients with migraine headache, the provider must certify the following statements are true:

- ☐ Use of botulinum toxin A is requested for treatment of chronic migraine headache.
- ☐ The patient has (or had prior to starting treatment with botulinum toxin A) a history of migraine headaches on 15 or more days per month with headaches lasting four hours a day or longer.
- ☐ The patient does not have episodic migraines, chronic daily headaches, cluster headaches, cervicogenic headaches or tension-type headaches.

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Additional information: _____

Physician's printed name and title: _____

TIN: _____

Signature: _____ Date: _____

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