Washington State Department of Labor & Industries

Botulinum Toxin for Non-Migraine Indications

Office of the Medical Director
PO Box 44321
Olympia WA 98504-4321

Please fax completed form, along with any supportive medical documentation to: 360-902-9170.

Claim Number	Injured Worker's Name

Section 1

Specify the agent:

☐ AbobotulinumtoxinA (Dysport) ☐ OnabotulinumtoxinA (Botox) ☐ DaxibotulinumtoxinA-lanm (Daxxify)
☐ IncobotulinumtoxinA (Xeomin) ☐ RimabotulinumtoxinB (Myobloc)

Specify indication: _____

Billing code(s): _____ Estimated date of procedure: _____

Is this the initial request? ☐ Yes — Go to Section 2 ☐ No — Go to Section 3

L&I covers a maximum of two (2) treatment cycles for FDA-approved indications, except for treatment of catastrophic injuries and migraines. For purposes of this coverage decision, catastrophic injury is defined as a severe injury from which recovery of physical function is not expected, such as a spinal cord injury. See coverage decision (Botulinum Toxins) for additional information.

Section 2

Criteria for initial course (all of the following must be met):

Is the condition being treated causally related to the industrial injury or occupational disease?	☐ Yes	☐ No
Is the condition being treated an FDA-approved indication for the requested botulinum toxin product?	☐ Yes	☐ No
Did the worker try conservative treatment, such as medication and physical therapy?	☐ Yes	☐ No

If "Yes", specify:

Treatment:	Duration:	Outcome:

Are the requested botulinum toxin injections part of a treatment plan with the goal of vocational rehabilitation and/or returning to work?	☐ Yes	☐ No

If "Yes", please summarize:

Section 3

Criteria for additional courses (all of the following must be met):

Were previous botulinum toxin injections well-tolerated (no severe adverse outcomes)?	☐ Yes	☐ No
Did previous botulinum toxin injections result in meaningful functional improvement, allowing the worker to engage in vocational rehabilitation or return to work?	☐ Yes	☐ No

If "Yes", please summarize:

Section 4

Prescriber Name	Prescriber Phone Number
Signature	Date

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Index: **RQST**