**Date:** [Date]

**TO:** [Insurance Company Name]
**ATTN:** Medical Review/Appeals Department
**FAX:** [Insurance Fax Number]

**RE:** Letter of Medical Necessity for Off-Label Botulinum Toxin Type A
**Patient Name:** [Patient Full Name]
**Date of Birth:** [Patient DOB]
**Member ID:** [Insurance ID Number]
**Group Number:** [Group Number]
**Case/Reference Number:** [Reference Number, if applicable]

To Whom It May Concern,

I am writing on behalf of my patient, [Patient Name], to request coverage for the off-label use of Botulinum Toxin Type A (CPT Code: 64615) to treat Chronic Tension-Type Headaches (ICD-10: G44.221).

**Clinical History:**
The patient has been diagnosed with Chronic Tension-Type Headaches, experiencing [Number] headache days per month for a duration of [Number] months/years. These headaches are characterized by [Description of symptoms, e.g., bilateral tightening, pericranial muscle tenderness] and significantly impair the patient's daily functioning and quality of life.

**Previous Failed Treatments:**
The patient has attempted and failed the following conventional therapies due to lack of efficacy or intolerable side effects:

- [Medication Name 1]: [Duration/Outcome]
- [Medication Name 2]: [Duration/Outcome]
- [Physical Therapy/Other Modality]: [Duration/Outcome]

**Medical Justification:**
While Botulinum Toxin is FDA-approved for Chronic Migraine, clinical evidence and peer-reviewed studies support its efficacy in treating refractory Chronic Tension-Type Headaches, particularly in patients with significant pericranial muscle tension. Given that the patient has exhausted standard prophylactic treatments, Botulinum Toxin is medically necessary to reduce headache frequency and prevent further disability.

**Treatment Plan:**
I plan to administer [Number of Units] of Botulinum Toxin via intramuscular injection into the [Specific Muscle Groups, e.g., frontal, temporal, occipital, and trapezius muscles] every [Number] weeks.

I request that you approve this treatment to prevent the progression of the patient's condition and reduce the need for emergency department visits or high-frequency analgesic use.

Please contact my office at [Phone Number] if you require additional documentation.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[NPI Number]
[Practice Name]