



Aetna Better Health®

Fax completed prior authorization request form to 855-799-2550 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at <https://www.aetnabetterhealth.com/kentucky/providers/pharmacy/>

Botulinum Toxins Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information									
Member Name (first & last):			Date of Birth:		Gender:		Height:		
					<input type="checkbox"/> Male	<input type="checkbox"/> Female			
Member ID:			City:		State:			Weight:	
Prescribing Provider Information									
Provider Name (first & last):			Specialty:		NPI#		DEA#		
Office Address:			City:		State:			Zip Code:	
Office Contact:				Office Phone			Office Fax:		
Dispensing Pharmacy Information									
Pharmacy Name:				Pharmacy Phone:			Pharmacy Fax:		
Requested Medication Information									
<input type="checkbox"/> Botox	<input type="checkbox"/> Dysport	<input type="checkbox"/> Myobloc	<input type="checkbox"/> Xeomin	<input type="checkbox"/> Other, please specify:					
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No				ICD-10 Code:			Diagnosis:		
What medication(s) have been tried and failed for diagnosis?									
Are there any contraindications to formulary medications?								<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please specify:									
Directions for Use:			Strength:			Dosage Form:			
			Quantity:		Day Supply:		Duration of Therapy/Use:		
Turn-Around Time for Review									
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> Urgent – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____						
Clinical Information									
<input type="checkbox"/> Migraine Prophylaxis									
<input type="checkbox"/> Botox									
Will Botox be used for prevention of chronic migraine (at least 15 days per month with headaches lasting 4 hours a day or longer)?				Yes	No	Will requested medication be used concurrently with CGRP antagonist?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
There was inadequate response OR intolerable side effects to at least THREE medications from TWO different classes of migraine headache prophylaxis for at least THREE months (check that apply):				<input type="checkbox"/> Beta-Blockers: propranolol, metoprolol, timolol, atenolol, nadolol					
				<input type="checkbox"/> Anticonvulsant: valproic acid or divalproex, topiramate					
				<input type="checkbox"/> Antidepressants: amitriptyline, venlafaxine					
				<input type="checkbox"/> ACE-Is / ARBs: lisinopril, candesartan, losartan, valsartan					
				<input type="checkbox"/> Calcium Channel Blockers: diltiazem, nifedipine, nimodipine, verapamil					
<input type="checkbox"/> Renewal Request ONLY									
Was migraine headache frequency reduced by at least 7 days per month by end of initial trial?			Yes	No	Was migraine headache duration reduced by at least 100 hours per month by end of initial trial?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Chronic Limb Spasticity									
<input type="checkbox"/> Botox			<input type="checkbox"/> Xeomin			<input type="checkbox"/> Dysport			
Is spasticity due to an injury to the brain or spinal cord, or along with a neurological disorder (for example, stroke, traumatic brain injury, multiple sclerosis, spinal cord injury, cerebral palsy)?							<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does member have upper limb spasticity?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have lower limb spasticity?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there failure with baclofen AND at least ONE other formulary muscle relaxant such as dantrolene?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there a trial of physical and/or occupational therapy?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

<input type="checkbox"/> Severe Primary Axillary Hyperhidrosis					
<input type="checkbox"/> Botox			<input type="checkbox"/> Dysport		
There was focal, visible, excessive sweating for at least SIX months without apparent cause with TWO of the following (check that apply):			<input type="checkbox"/> Interferes with daily activities		
			<input type="checkbox"/> Bilateral and relatively symmetric		
			<input type="checkbox"/> Onset before 25 years of age		
			<input type="checkbox"/> Focal sweating stops during sleep		
			<input type="checkbox"/> Family history of idiopathic hyperhidrosis		
<input type="checkbox"/> At least one episode per week					
Was there failure with topical aluminum chloride (hexahydrate)?					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Neurogenic Bladder					
<input type="checkbox"/> Botox					
Is diagnosis of urinary incontinence due to detrusor overactivity associated with neurologic condition?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Was there trial of behavioral therapy (for example, bladder training, bladder control strategies, pelvic floor muscle training, fluid management) for at least 8-12 weeks?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Was there a trial and failure with TWO formulary urinary anticholinergics (for example, oxybutynin, trospium, tolterodine)?					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Overactive Bladder					
<input type="checkbox"/> Botox					
Was a trial of behavioral therapy (for example, bladder training, bladder control strategies, pelvic floor muscle training, fluid management) for at least 8-12 weeks?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Was there trial and failure with TWO formulary urinary anticholinergics (for example, oxybutynin, trospium, tolterodine)?					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Esophageal Achalasia					
<input type="checkbox"/> Botox					
Has member remained symptomatic despite surgical myotomy or pneumatic dilation?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Is member at high surgical risk or is unwilling to undergo surgical myotomy or pneumatic dilation?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chronic Anal Fissures					
<input type="checkbox"/> Botox					
Was there a trial and failure with nitroglycerin ointment 0.4% (Rectiv) AND bulk fiber supplements OR stool softeners OR sitz baths for at least TWO months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Was endoscopy completed to rule out Crohn's disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Chronic Sialorrhea					
<input type="checkbox"/> Botox		<input type="checkbox"/> Myobloc		<input type="checkbox"/> Xeomin	
Was there trial and failure with anticholinergic such as glycopyrrolate (pediatric use 3-16) or benztropine (adults)?					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Focal Spasticity or Equinus Gait due to Cerebral Palsy					
<input type="checkbox"/> Botox			<input type="checkbox"/> Dysport		
Is member enrolled in OR is currently being managed with physical and/or occupational therapy?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records					

Signature affirms that information given on this form is true and accurate and reflects office notes.	
Prescribing Provider's Signature: _____	Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required
Standard turnaround time is 24 hours. You can call 855-300-5528 to check the status of a request.