

Aetna Better Health®

Fax completed prior authorization request form to 855-296-0323 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 www.aetnabetterhealth.com/newjersey/providers/pharmacy

Botulinum Toxins Pharmacy Prior Authorization Request Form

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

Member Name (first & last):	Member Informati		euicai testing r	elevant	to requ	uesi	t snowing	y med	uicai justific	ation	are requ	irea to	supp	ort al	agno	515	
Member ID:				Date of Birth:					Gender:				Height:				
Prescribing Provider Information	(-					J .				
Provider Name (first & last):	Member ID:				City:				State:				W	Weight:			
Office Contact: Office Contact: Office Contact: Office Contact: Office Contact: Dispensing Pharmacy Information Pharmacy Name: Pharmacy Name: Pharmacy Name: Pharmacy Phone: Pharmacy Fax: Pharmacy Phone: Pharmacy Phone: Pharmacy Phone: Pharmacy Phone: Pharmacy Phone: Pharmacy Fax: Pharmacy Fax: Pharmacy Fax: Pharmacy Phone:	Prescribing Provid	ler Information															
Office Contact: Office Phone Office Fax:					Specialty:				NPI#			DEA#					
Pharmacy Name:	Office Address:				City:				State:			Zip Code:					
Pharmacy Name:	Office Contact:				Office Phone				Office F			Fax:					
Requested Medication Information Botox	Dispensing Pharm	acy Information															
Botox	Pharmacy Name:			Pharmacy Pho				Phone	one: Pharma			acy Fax:					
Medication requires is NOT for an FDA approved, or compendia- supported diagnosis (circle one): Yes No What medication(s) have been tried and failed for diagnosis? Are there any contraindications to formulary medications? Strength:	Requested Medica	ation Information															
Supported diagnosis (circle one): Yes No	□ Botox	☐ Dysport	☐ Myobloc		☐ Xeomin ☐ Other, please specify:						ecify:						
What medication(s) have been tried and failed for diagnosis? Are there any contraindications to formulary medications? If yes, please specify: Directions for Use: Strength: Quantity: Day Supply: Duration of Therapy/Use: Turn-Around Time for Review Standard – (24 hours) Standard – (24 hours) Standard – (24 hours) Standard – (24 hours) Signature: Clinical Information Migraine Prophylaxis 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)? There was inadequate response OR intolerable side effects to at least TWO months (check that apply): Renewal Request ONLY Was migraine headache frequency reduced by at least 7 days per month by end of initial trial? No Was migraine headache duration reduced by at least 700 hours per month by end of initial trial?					ompendia- ICD-10 Code:				Diagnosis:								
Strength: Doay Supply: Doay Supply: Duration of Therapy/Use: Turn-Around Time for Review Duration of Therapy/Use: Doay Supply: Doay Supply: Duration of Therapy/Use: Doay Supply: Doay Suppl				agnosis?							1						
Directions for Use: Quantity: Day Supply: Duration of Therapy/Use:	=		mulary medica	tions?	ions?									Yes		No	
Turn-Around Time for Review Standard – (24 hours) Signature: Ouygent – 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: Signature																	
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least 7 days per month by end of initial trial? at least 100 hours per month by end of initial	-		educed by at	□Yes	□No	5	Was mia	raine	headache di	uratio	n reduce	d bv		Yes		No	
	1					_										-	

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Chronic Limb Spasticity											
□ Botox		Xeomin			□ Dysport						
Is spasticity due to an injury to the brain or sp	inal cor	d, or along v	with a ne	urol	ogical disorder (for example, stroke,		Yes		No		
traumatic brain injury, multiple sclerosis, spir	nal cord	injury, cere	bral palsy	y)?							
Does member have upper limb spasticity?		□ Yes	□ No)	Does member have lower limb spasticity?		Yes		No		
Was there failure with baclofen AND at least	☐ Yes	□ No	,	Was there a trial of physical and/or		Yes		No			
other formulary muscle relaxant such as			occupational therapy?								
dantrolene?											
Severe Primary Axillary Hyperhidrosis											
□ Botox]	Dysport						
There was focal, visible, excessive sweating	for at lea	st SIX mon	ths witho	ut	☐ Interferes with daily activities						
apparent cause with TWO of the following (c	heck tha	at apply):			☐ Bilateral and relatively symmetric						
					☐ Onset before 25 years of age						
					☐ Focal sweating stops during sleep						
					☐ Family history of idiopathic hyperhic	Irosis					
					☐ At least one episode per week						
Was there failure with topical aluminum chlo	ride (he)	kahydrate)?)				Yes		No		
Neurogenic Bladder											
□ Botox											
Is diagnosis of urinary incontinence due to de	etrusor c	veractivity	associate	ed v	vith neurologic condition?		Yes		No		
Was there trial of behavioral therapy (for exa	mple, bl	adder traini	ng, blado	der	control strategies, pelvic floor muscle		Yes		No		
training, fluid management) for at least 8-12	weeks?										
Was there a trial and failure with TWO formu	lary urin	ary anticho	linergics	(for	example, oxybutynin, trospium,		Yes		No		
tolterodine)?											
Overactive Bladder											
□ Botox											
Was a trial of behavioral therapy (for example		er training,	bladder c	cont	rol strategies, pelvic floor muscle		Yes		No		
training, fluid management) for at least 8-12							Yes				
Was there trial and failure with TWO formulary urinary anticholinergics (for example, oxybutynin, trospium,									No		
tolterodine)?											
Esophageal Achalasia											
Has member remained symptomatic	□ Ye	es 🗆 N	o le me	amh	per at high surgical risk or is unwilling to	Т	Yes		No		
despite surgical myotomy or pneumatic	' '	,			surgical myotomy or pneumatic		163		140		
dilation?				dilation?							
Chronic Anal Fissures			- Citati	011.							
□ Botox											
Was there a trial and failure with nitroglycering	<u> </u>	☐ Yes		lo	Was and assamy completed to rule out		Yes		No		
ointment 0.4% (Rectiv) AND bulk fiber suppli		L 163		10	Was endoscopy completed to rule out Crohn's disease?		163		NO		
OR stool softeners OR sitz baths for at least T					Groffin's disease:						
months?	WO										
Chronic Sialorrhea						_		_			
		Myobloc			□ Xeomin						
□ Botox □ Myobloc □ Xeomin Was there trial and failure with anticholinergic such as glycopyrrolate (pediatric use 3-16) or benztropine (adults)?									No		
			Otate (pe	uia	the use 5 Toy or benziropine (addits):		Yes	Ľ	110		
Focal Spasticity or Equinus Gait due to Cer	ebral Pa	ılsy									
□ Botox					sport						
Is member enrolled in OR is currently being r	nanaged	d with physi	cal and/	or o	ccupational therapy?		Yes		No		
Additional information the prescribing pro	vider fe	els is impor	tant to tl	his ı	review. Please specify below or submit r	nedic	cal rec	ords			

Prescribing Provider's Signature:	 Date:	
Signature affirms that information given on this form is true an	fice notes.	

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 855-232-3596 to check the status of a request.

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