aetna®

MEDICARE FORM

Botulinum Toxins Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Illinois MMP:
FAX: 1-855-320-8445
PHONE: 1-866-600-2139

For other lines of business:
Please use other form.

Note: Botox and Myobloc are non-preferred. The preferred products are Dysport and Xeomin.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: _____ lbs or _____ kgs Patient Height: _____ inches or _____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

C. PRESCRIBER INFORMATION

First Name:	Last Name:			*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:		Phone:		

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ *Outpatient Dialysis Center* ☐ Physician's Office
☐ Retail Pharmacy ☐ Specialty Pharmacy
☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for ☐ Botox ☐ Dysport ☐ Myobloc ☐ Xeomin **Dose:** _____ **Frequency:** _____
HCPCS Code: _____ **Please note - requests over 400 units per day may require a medical exception review**

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ☐ _____ **Secondary ICD Code :** _____ **Other ICD Code:** _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

Note: Botox and Myobloc are non-preferred. The preferred products are Dysport and Xeomin.

☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days?
☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Dysport (abobotulinumtoxinA) ☐ Xeomin (incobotulinumtoxinA)?

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)
☐ Dysport (abobotulinumtoxinA) ☐ Xeomin (incobotulinumtoxinA)?

_____

_____

Which of the following is the patient being treated for? *(Clinical documentation must support the symptoms specified)*

☐ **Blepharospasm –** ☐ Yes ☐ No Does the patient have intermittent or sustained closure of the eyelids caused by involuntary contractions of the orbicularis oculi muscle (including Blepharospasm associated with dystonia and benign essential Blepharospasm)?

☐ **Cervical dystonia** (spasmodic torticollis) of moderate or greater severity- *Please check all that apply:*
☐ Clonic and/or tonic involuntary contractions of multiple neck muscles
☐ Sustained head torsion and/or tilt with limited range of motion in the neck
☐ Alternative causes of symptoms have been ruled out, including chronic neuroleptic treatment, contractures, or other neuromuscular disorders
Please indicate the duration the symptoms have persisted: _____ months

☐ **Chronic anal fissure –** Please indicate the duration the patient has experienced the fissure: _____ months
☐ Yes ☐ No Is the condition unresponsive to conservative therapeutic measures (e.g., nitroglycerin ointment, topical diltiazem cream)

Continued on next page

aetna®

MEDICARE FORM

Botulinum Toxins Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Illinois MMP:
FAX: 1-855-320-8445
PHONE: 1-866-600-2139

For other lines of business:
Please use other form.

Note: Botox and Myobloc are non-preferred. The preferred products are Dysport and Xeomin.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

☐ **Craniopharyngeal dysfunction**
- ☐ Yes ☐ No Is the patient a candidate for surgery?
- ☐ Yes ☐ No Is the patient a candidate for endoscopic balloon dilation?

☐ **Esophageal achalasia –** *Please check all that apply:*
- ☐ At high risk of complications of pneumatic dilation or surgical myotomy ☐ Advanced age or limited life expectancy ☐ Failed conventional therapy
- ☐ Epiphrenic diverticulum or hiatal hernia, both of which increase the risk of dilation-induced perforation ☐ Sigmoid-shaped esophagus

☐ Failed a prior myotomy or dilation ☐ Previous dilation-induced perforation ☐ Other: _____

☐ **First Bite Syndrome –** *Please check all that apply:*
- ☐ Experienced persistent symptoms
- ☐ Failed trial of analgesics - Please provide name and date range used: Name: _____ Date range: _____
- ☐ Failed trial of antidepressants - Please provide name and date range used: Name: _____ Date range: _____
- ☐ Failed a trial of gabapentin? If yes, please provide the date range used: Date range: _____

☐ **Facial myokymia and trismus** associated with post-radiation myokymia

☐ **Frey's syndrome**

☐ **Focal dystonias –** *Please check all that apply:*
- ☐ Jaw-closing oromandibular dystonia, characterized by dystonic movements involving the jaw, tongue, and lower facial muscle
- ☐ Adductor laryngeal dystonia ☐ Focal dystonias in corticobasilar degeneration
- ☐ Symptomatic torsion dystonia (but not lumbar torsion dystonia) ☐ Lingual dystonia

☐ **Focal hand dystonias (i.e. writer's cramp) –** *Please check all that apply:*
- ☐ Abnormal muscle tone causing persistent pain and/or interfering with functional ability ☐ Failure of conservative medical therapy

☐ **Hirschsprung's disease** with internal sphincter achalasia following endorectal pull-through.

☐ **Hyperhidrosis**
- ☐ Yes ☐ No Does the patient have intractable, disabling focal primary hyperhidrosis?
  - → *What is the* treatment location? ☐ Axillary ☐ Palmar ☐ Plantar ☐ Scalp ☐ Other: _____

Please check all symptoms that apply:
- ☐ Member is unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating if sweating is episodic
- ☐ Significant disruption of professional and/or social life has occurred because of excessive sweating
- ☐ Topical aluminum chloride or other extra-strength antiperspirants are ineffective or result in a severe rash

☐ **Laryngeal spasm**

☐ **Limb spasticity –** *Please check all that apply:*
- ☐ Upper limb spasticity ☐ Limb spasticity due to multiple sclerosis ☐ Hereditary spastic paraplegia
- ☐ Spastic hemiplegia, such as due to stroke or brain injury
- ☐ Equinus varus deformity or other lower limb spasticity in children with cerebral palsy
  - → ☐ Yes ☐ No Does the patient have evidence of the **absence** of significantly fixed deformity?
- ☐ Limb spasticity due to other demyelinating diseases of the central nervous system (including adductor spasticity and pain control in children undergoing adductor-lengthening surgery, as well as children with upper extremity spasticity)
- ☐ Documentation of abnormal muscle tone interfering with functional ability or is expected to result in joint contracture with future growth
- ☐ Documented failure to standard medical treatments
- ☐ Surgical intervention is the last option
- ☐ Treatment being requested to enhance function or to allow additional therapeutic modalities to be employed

☐ **Medically refractory upper extremity tremor –** ☐ Yes ☐ No Does the condition interfere with activities of daily living (ADLs)?
For *continuation of therapy:* ☐ Yes ☐ No Has the patient responded to a trial of botulinum toxin that has enabled ADLs or communication?

☐ **Migraines –** *Please check all that apply:*
- ☐ 5 or more migraine attacks without aura ☐ Duration of the attacks lasted 4 hours to 3 days
- ☐ 2 or more migraine attacks with aura ☐ Prevention of chronic (more than 14 days per month) of migraines

☐ Yes ☐ No Has the patient had 2 or more of the following: aggravation by or causing avoidance of routine physical activity; moderate or severe pain intensity; pulsating; and/or unilateral (affecting half the head)?

☐ Yes ☐ No Has the patient had any of the following: nausea and/or vomiting OR sensitivity to both light and sound?

☐ Yes ☐ No Is the patient an adult who has tried and failed **at least 3 medications** selected from at least two classes of migraine headache prophylaxis medications for at least 2 months (60 days) for each medication?
- → Indicate the drug classes that were tried: ☐ ACE inhibitors/ARBs ☐ Anti-depressants ☐ Anti-epileptic drugs ☐ Beta blockers ☐ Calcium channel blockers

Continued on next page

aetna®

MEDICARE FORM

Botulinum Toxins Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Illinois MMP:
FAX: 1-855-320-8445
PHONE: 1-866-600-2139

For other lines of business:
Please use other form.

Note: Botox and Myobloc are non-preferred. The preferred products are Dysport and Xeomin.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(continued)* – Required clinical information must be completed in its entirety for all precertification requests.

For migraine continuation requests:

☐ Yes ☐ No Has the frequency of migraine headaches been reduced by at least 7 days per month by the end of the initial trial?

☐ Yes ☐ No Has the duration of the migraine headaches been reduced by at least 100 total hours per month by the end of the initial trial?

☐ **Neurogenic detrusor over activity –** ☐ Yes ☐ No Is the condition resulting from multiple sclerosis, spinal cord injury, or other neurologic condition?

If yes, please select diagnosis: ☐ Multiple Sclerosis ☐ spinal cord injury ☐ other neurologic condition – specify: _____

Please check all that apply: ☐ Detrusor over activity confirmed by urodynamic testing ☐ Documented failure of behavioral therapy

☐ Failure/intolerance to at least one adequately titrated anticholinergic medication (e.g. oxybutynin chloride, trospium chloride)

→ *Please indicate the name and date range tried*: Name: _____ Date: _____

☐ **Orofacial tardive dyskinesia –** ☐ Yes ☐ No Have conventional therapies have been tried and failed (e.g., benzodiazepines, clozapine, tetrabenazine)?

☐ Documented failure/intolerance to an OTC bladder medication (oxybutynin transdermal patch (Oxytrol for Women).

→ Please indicate the medications tried: Medication #1: _____ Date: _____

Medication #2: _____ Date: _____

☐ **Overactive bladder**

☐ Yes ☐ No Will prophylactic antibiotics be administered 1-3 days prior to treatment, on the treatment day, and 1-3 days post-treatment?

☐ Yes ☐ No Will the requested medication be used in combination with other anticholinergic agents?

Please check all that apply:

☐ Symptoms of urinary incontinence, urgency, and frequency

☐ Documented behavioral therapy failure

☐ Currently have an acute urinary tract infection or acute urinary retention

☐ Documented failure/intolerance to adequately titrated overactive bladder medications (e.g., oxybutynin, trospium, Myrbetriq®, Vesicare®)

→ *Please provide the name and date ranges:* Medication #1: _____ Date: _____

Medication #2: _____ Date: _____

Medication #3: _____ Date: _____

☐ **Painful Bruxism**

☐ **Palatal Myclonus** with disabling symptoms (e.g., objective, intrusive clicking tinnitus)

☐ **Post-facial** (7th cranial) **nerve palsy synkinesis** (hemifacial spasms)

☐ Yes ☐ No Are symptoms characterized by sudden, unilateral, synchronous contractions of muscles innervated by the facial nerve?

☐ **Post-parotidectomy sialocele**

☐ Yes ☐ No Has the patient failed conservative management?

→ Please identify which type of conservative management treated failed: ☐ Antibiotic

→ *Please provide name of antibiotic and date ranged used:*

Medication #1: _____ Date: _____

☐ Pressure dressing

☐ Serial percutaneous needle aspiration

☐ Other treatment type- specify: _____

☐ **Ptyalism/sialorrhea** (excessive secretion of saliva, drooling) **–** *Please check all that apply:*

☐ Refractory to pharmacotherapy (including anticholinergics)

☐ Documentation of medically significant complications of sialorrhea, such as chronic skin maceration or infections that cannot be controlled with topical treatments or hygiene

☐ **Strabismus** (esotropia horizontal for deviations < 50 prism diopters, vertical strabismus or persistent cranial nerve VI palsies (including gaze palsies accompanying diseases, such as neuromyelitis optica, Schilder's disease) **–** *Please check all that apply:*

☐ Uncorrected congenital strabismus or no binocular fusion ☐ Previously failed corrective surgery ☐ Spontaneous recovery of strabismus unlikely

☐ Medication being prescribed as an alternative to surgery ☐ Interference with normal visual system development is likely to occur

☐ **Other Condition** – Please attach rationale for use

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.