Botox® (onabotulinumtoxinA) Injectable Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 **(TTY:**711**)**
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

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:	

Specialty *(Check one):* ☐ Dermatologist ☐ Neurologist ☐ Orthopedist ☐ Otolaryngologist ☐ Physiatrist ☐ Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Botox (onabotulinumtoxinA) Dose: _____ **Frequency:** _____
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.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is therapy prescribed for cosmetic purposes (e.g., treatment of wrinkles or uncorrected congenital strabismus and no binocular fusion)?

☐ **Achalasia**
- ☐ Yes ☐ No Has the patient tried and failed or is a poor candidate for conventional therapy such as pneumatic dilation and surgical myotomy?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a gastroenterologist, proctologist, or colorectal surgeon?

☐ **Blepharospasm**
- ☐ Yes ☐ No Has the patient been diagnosed with blepharospasm, including blepharospasm associated with dystonia, benign essential blepharospasm or VII nerve disorder?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist or ophthalmologist?

☐ **Cervical dystonia (e.g., torticollis)**
- ☐ Yes ☐ No Prior to initiating therapy with the requested drug, was/is there abnormal placement of the head with limited range of motion in the neck?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?

☐ **Chronic anal fissure**
- ☐ Yes ☐ No Has the patient failed to respond to first line therapy for chronic anal fissures such as topical calcium channel blockers or topical nitrates?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a gastroenterologist, proctologist, or colorectal surgeon?

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

☐ **Chronic migraine prophylaxis**
Prior to initiating therapy, how many days per month does (did) the patient experience headaches? ☐ 15 days or more ☐ Less than 15 days
☐ Yes ☐ No Do (did) the patient's headaches last 4 hours or longer on at least 8 days per month?
☐ Yes ☐ No Has the patient completed an adequate trial of **2** oral migraine preventative therapies coming from at least **2** of the following classes: antidepressants (e.g., amitriptyline, venlafaxine), **or** antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), **or** beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)?
→ ☐ Yes ☐ No Does the patient have a contraindication to any of the following classes: antidepressants (e.g., amitriptyline, venlafaxine), **or** antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), **or** beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)?
→ Please indicate the number of classes the patient has a contraindication to:
☐ One class **or** ☐ Two classes or more
→ Please indicate the number of classes the patient had an adequate trial: ☐ One class **or** ☐ Two classes or more
Please indicate how many days was the trial of each drug: ☐ 60 days or more ☐ Less than 60 days
☐ Yes ☐ No Does the patient have signs and symptoms consistent with chronic migraine diagnostic criteria as defined by the International Headache Society (IHS)?
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, pain specialist, or physiatrist?

☐ **Essential tremor**
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, pain specialist, or physiatrist?

☐ **Excessive salivation (chronic sialorrhea, ptyalism)**
☐ Yes ☐ No Is the patient refractory to pharmacotherapy (e.g., anticholinergics)?
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist or otolaryngologist?

☐ **Facial myokymia**
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?

☐ **First bite syndrome**
☐ Yes ☐ No Has the patient failed to experience relief from analgesics, antidepressants, or anticonvulsants?
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist or oncologist?

☐ **Focal hand dystonia**
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?

☐ **Hemifacial spasm**
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?

☐ **Hirschsprung disease with internal sphincter achalasia**
☐ Yes ☐ No Has the patient undergone an endorectal pull through to treat the Hirschsprung disease with internal sphincter achalasia?
☐ Yes ☐ No Is the patient refractory to laxative therapy?
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a gastroenterologist, proctologist, or colorectal surgeon?

☐ **Limb spasticity**
Please indicate which of the following applies to the patient: ☐ Upper limb spasticity ☐ Lower limb spasticity
☐ Yes ☐ No Does the patient have a primary diagnosis of upper or lower limb spasticity or as a symptom of a condition causing limb spasticity (including focal spasticity or equinus gait due to cerebral palsy)?
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?

☐ **Myofascial pain syndrome**
Please indicate which of the following treatments has the patient tried and failed for myofascial pain syndrome:
☐ Physical therapy ☐ Injection of local anesthetics into trigger points ☐ Injection of corticosteroids into trigger points
Please indicate how many treatments were tried and failed: _____
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, orthopedist, otolaryngologist, or physiatrist?

☐ **Orofacial tardive dyskinesia**
☐ Yes ☐ No Has the patient tried and failed conventional therapies for orofacial tardive dyskinesia (e.g., benzodiazepines, clozapine, or tetrabenazine)?
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, pain specialist, or physiatrist?

☐ **Oromandibular dystonia**
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist or otolaryngologist?

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

☐ **Overactive bladder with urinary incontinence**
- ☐ Yes ☐ No Prior to initiating therapy with the requested drug, along with urinary incontinence, does (did) the patient experience urgency and frequency?
- ☐ Yes ☐ No Has the patient tried and failed behavioral therapy?
- ☐ Yes ☐ No Has the patient had an inadequate response or experienced intolerance to at least **2** agents from either of the following classes?
  - ☐ Anticholinergic medications (e.g., Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin]
  - ☐ Beta-3 adrenergic agonist (e.g., Myrbetriq [mirabegron], Gemtesa [vibegron])
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with neurologist, urologist, or gynecologist?

☐ **Painful bruxism**
- ☐ Yes ☐ No Did the patient try and have an inadequate response to a night guard?
- ☐ Yes ☐ No Did the patient have an inadequate response to pharmacotherapy such as diazepam?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist or otolaryngologist?

☐ **Palatal myoclonus**
- ☐ Yes ☐ No Prior to initiating therapy with the requested drug, does (did) the patient have disabling symptoms (e.g., intrusive clicking tinnitus)?
- ☐ Yes ☐ No Did the patient have an inadequate response to clonazepam, lamotrigine, carbamazepine, or valproate?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist or otolaryngologist?

☐ **Primary axillary, palmar, and gustatory (Frey's syndrome) hyperhidrosis**
- ☐ Yes ☐ No Has significant disruption of professional and/or social life occurred because of excessive sweating?
- ☐ Yes ☐ No Has the patient tried topical aluminum chloride or other extra-strength antiperspirants?
  - → ☐ Yes ☐ No Was the topical aluminum chloride or other extra-strength antiperspirant ineffective or resulted in a severe rash?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, internist, or dermatologist?

☐ **Spasmodic dysphonia (laryngeal dystonia)**
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist or otolaryngologist?

☐ **Strabismus**
- ☐ Yes ☐ No Is interference with the patient's normal visual system development is likely to occur? Note: Strabismus repair is considered cosmetic in adults with uncorrected congenital strabismus and no binocular fusion.
- ☐ Yes ☐ No Is the patient likely to have spontaneous recovery?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist or ophthalmologist?

☐ **Urinary incontinence associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis)**
- ☐ Yes ☐ No Has the patient tried and failed behavioral therapy?
- ☐ Yes ☐ No Has the patient had an inadequate response or experienced intolerance to **1** agent from either of the following classes?
  - ☐ Anticholinergic medications (e.g., Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin]
  - ☐ Beta-3 adrenergic agonist (e.g., Myrbetriq [mirabegron])
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, urologist, or gynecologist?

For All Continuation Requests (clinical documentation required):

☐ Yes ☐ No Was the requested drug effective for treating the diagnosis or condition?

☐ **Chronic migraine prophylaxis only**
- ☐ Yes ☐ No Has the patient achieved or maintained a reduction in monthly headache frequency since starting the requested drug therapy?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, pain specialist, or physiatrist?

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.