Dysport® (abobotulinumtoxinA) 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 #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	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)*: ☐ **Neurologist** ☐ **Ophthalmologist** ☐ **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: **Dysport (abobotulinumtoxinA) Dose:** _____ **Frequency:** _____

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):

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

For Initiation Requests (clinical documentation required):

☐ **Blepharospasm, including blepharospasm associated with dystonia and benign essential blepharospasm**
☐ 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, 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?

☐ **Excessive salivation (chronic sialorrhea)**
☐ 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?

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

☐ **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, or physiatrist?

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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.

☐ **Primary axillary 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, dermatologist, or internist?

For Continuation Requests (clinical documentation required):

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

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.