Botox® (onabotulinumtoxinA) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form
GR-68776-3

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):* ☐ **Oncologist** ☐ **Hematologist** ☐ **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 conventional therapy such as pneumatic dilation and surgical myotomy?

☐ **Blepharospasm**

☐ **Cervical dystonia** (e.g., torticollis)
☐ Yes ☐ No Prior to initiating therapy with Botox (onabotulinumtoxinA), was/is there sustained head torsion and/or tilt with limited range of motion with the patient's cervical dystonia?

☐ **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?

☐ **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
How many hours does (did) the patient's headache last? ☐ Longer than 4 hours ☐ 4 hours or less
☐ Yes ☐ No Has the patient completed an adequate trial of at least 3 oral migraine preventative therapies medications selected from at least two classes?
→ Please indicate the drug classes that were tried: ☐ Anti-depressants (e.g., amitriptyline, nortriptyline, venlafaxine) ☐ Anti-epileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium) ☐ Beta blockers (e.g., metoprolol, propranolol, timolol, atenolol, nadolol) ☐ Calcium channel blockers (e.g., amlodipine, diltiazem, felodipine)
Please indicate how many days was the trial of each medication: ☐ 60 days or more ☐ Less than 60 days
☐ Yes ☐ No Will Botox (onabotulinumtoxinA) be used concomitantly with any CGRP-inhibitors (for example, Aimovig)?
Please indicate how many of the following applies to the patient's headache: ☐ Aggravated by routine movement ☐ Moderate to severe pain intensity ☐ Pulsating ☐ Unilateral
Please indicate how many of the following symptoms applies to the patient's headache: ☐ Nausea/vomiting ☐ Sensitivity to light ☐ Sensitivity to sound

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FAX: 1-888-267-3277

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

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.

☐ **Essential tremor**

☐ **Excessive salivation (chronic sialorrhea)**
- ☐ Yes ☐ No Is the patient refractory to pharmacotherapy (for example, anticholinergics)?

☐ **Facial myokymia**

☐ **First bite syndrome**
- ☐ Yes ☐ No Has the patient failed to experience relief from analgesics, antidepressants, or anticonvulsants?

☐ **Focal hand dystonia**

☐ **Hemifacial spasm**

☐ **Hirschsprung disease with internal sphincter achalasia**
- ☐ Yes ☐ No Is the patient's Hirschsprung disease with internal sphincter achalasia following endorectal pull through?
- ☐ Yes ☐ No Is the patient refractory to laxative therapy?

☐ **Limb spasticity**
- ☐ Upper limb spasticity ☐ Lower limb spasticity

☐ **Myofascial pain syndrome**

Please indicate how many 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

☐ **Orofacial tardive dyskinesia**
- ☐ Yes ☐ No Has the patient tried and failed conventional therapies for orofacial tardive dyskinesia (examples: benzodiazepines, clozapine, or tetrabenazine)?

☐ **Oromandibular dystonia**

☐ **Overactive bladder with urinary incontinence**
- ☐ Yes ☐ No Prior to initiating therapy with Botox (onabotulinumtoxinA) - 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 two anticholinergic medications (examples: Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin])?

☐ **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?

☐ **Palatal myoclonus**
- ☐ Yes ☐ No Prior to initiating therapy with Botox (onabotulinumtoxinA) - does (did) the patient have disabling symptoms (for example, intrusive clicking tinnitus)?
- ☐ Yes ☐ No Did the patient have an inadequate response to clonazepam, lamotrigine, carbamazepine, or valproate?

☐ **Primary axillary, palmer, or 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 Is the patient unresponsive or unable to tolerate pharmacotherapy prescribed for excessive sweating (e.g., anticholinergics, beta-blockers, or benzodiazepines)?

☐ **Spasmodic dysphonia (laryngeal dystonia)**

☐ **Strabismus**
- ☐ Yes ☐ No Is interference with the patient's normal visual system likely to occur?
- ☐ Yes ☐ No Is the patient likely to have spontaneous recovery?

☐ **Urinary incontinence 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 an anticholinergic medication (examples: Vesicare [solifenacin], Enablex [darifenacin], Toviaz [fesoterodine], Detrol/Detrol LA [tolterodine], Sanctura/Sanctura XR [trospium], Ditropan XL [oxybutynin])?

☐ **Other:** _____

For Continuation Requests:

☐ **Chronic migraine prophylaxis**
- ☐ Yes ☐ No Has the patient achieved or maintained a reduction in monthly headache frequency since starting Botox therapy?

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.