



# Botulinum Toxins Injectable Medication Precertification Request

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

Aetna Precertification Notification  
503 Sunport Lane, Orlando, FL 32809

Phone: 1-866-503-0857

FAX: 1-888-267-3277

For Medicare Advantage Part B:

FAX: 1-844-268-7263

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

### B. INSURANCE INFORMATION

Aetna Member ID #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

### C. PRESCRIBER INFORMATION

First Name:	Last Name:	(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.		
Address:	City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:
Provider Email:	Office Contact Name:	UPIN:		

Specialty (Check one):  Oncologist  Hematologist  Other: \_\_\_\_\_

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	<b>Dispensing Provider/Pharmacy:</b> <i>Patient Selected choice</i> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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### E. PRODUCT INFORMATION

Request is for  Botox  Dysport  Myobloc  Xeomin 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.

**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)

**Detrusor-sphincter dyssynergia** –  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  Dyssynergia over activity confirmed by urodynamic testing  Behavioral therapy failure

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: \_\_\_\_\_

**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: \_\_\_\_\_

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.**

- 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
  - Symptomatic torsion dystonia (but not lumbar torsion dystonia)
  - Focal dystonias in corticobasilar degeneration
  - 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
  - Please indicate the medications and date ranges tried: Medication #1: \_\_\_\_\_ Date: \_\_\_\_\_  
Medication #2: \_\_\_\_\_ Date: \_\_\_\_\_  
Medication #3: \_\_\_\_\_ Date: \_\_\_\_\_
- 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: \_\_\_\_\_

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

**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?

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

Refractory to pharmacotherapy (including anticholinergics)

Documentation of medically significant complications of sialorrhoea, 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.