



Xeomin® (incobotulinumtoxinA) 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: 1-866-752-7021
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 #: _____	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 #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:	Dispensing Provider/Pharmacy: (Patient selected choice)
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy
<input type="checkbox"/> Outpatient Infusion Center Phone: _____	<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____
Center Name: _____	Name: _____
<input type="checkbox"/> Home Infusion Center Phone: _____	Address: _____
Agency Name: _____	Phone: _____ Fax: _____
<input type="checkbox"/> Administration code(s) (CPT): _____	TIN: _____ PIN: _____
Address: _____	

E. PRODUCT INFORMATION

Request is for: **Xeomin (incobotulinumtoxinA)** 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)?

Blepharospasm

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

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

Upper limb spasticity

Other: _____

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.