aetna®

# MEDICARE FORM

# Botulinum Toxins Injectable Medication Precertification Request



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

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

**For other lines of business:**
Please use other form.

**Note: Botox and Myobloc are non-preferred. The preferred products are Dysport and Xeomin.**

**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:

## 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: |
| Office Contact Name: | | | | Phone: | |

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

**Dispensing Provider/Pharmacy:**
☐ *Outpatient Dialysis Center* ☐ Physician's Office
☐ Retail Pharmacy ☐ Specialty Pharmacy
☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____
NPI: _____

## E. PRODUCT INFORMATION

**Request is for** ☐ Botox ☐ Dysport ☐ Myobloc ☐ Xeomin **Dose:** _____ **Frequency:** _____
**HCPCS Code**: _____ **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.

**Note: Botox and Myobloc are non-preferred. The preferred products are Dysport and Xeomin.**
☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Dysport (abobotulinumtoxinA) or Xeomin (incobotulinumtoxinA)?
Please explain if there are any other medical reason(s) that the patient cannot use Dysport (abobotulinumtoxinA) or Xeomin (incobotulinumtoxinA).

_____

_____

***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)

☐ **Criopharyngeal dysfunction**
- ☐ Yes ☐ No Is the patient a candidate for surgery?
- ☐ Yes ☐ No Is the patient a candidate for endoscopic balloon dilation?

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| | | | |

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

☐ **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: _____

☐ **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 ☐ Focal dystonias in corticobasilar degeneration
- ☐ Symptomatic torsion dystonia (but not lumbar torsion dystonia) ☐ 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

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| | | | |

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

**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: _____

☐ **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?

☐ **Post-parotidectomy sialocele**

☐ Yes ☐ No Has the patient failed conservative management?

→ Please identify which type of conservative management treated failed: ☐ Antibiotic

→ *Please provide name of antibiotic and date ranged used:*

Medication #1: _____ Date: _____

☐ Pressure dressing

☐ Serial percutaneous needle aspiration

☐ Other treatment type- specify: _____

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

☐ Refractory to pharmacotherapy (including anticholinergics)

☐ Documentation of medically significant complications of sialorrhea, 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.