



# Xeomin® (incobotulinumtoxinA) Injectable Medication Precertification Request

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

Aetna Precertification Notification

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"/> Neurologist <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, including blepharospasm associated with dystonia and benign essential blepharospasm**

**Cervical dystonia (e.g., torticollis)**  
 Yes  No Prior to initiating therapy with Xeomin, was/is there abnormal placement of the head with limited range of motion in the neck?

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

**Upper limb spasticity**  
 Yes  No Is the spasticity either the primary diagnosis or a symptom of a condition causing limb spasticity?

### 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.