Botox® (onabotulinumtoxinA) Injectable Medication Precertification Request

(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

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):* ☐ **Neurologist** ☐ **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, including blepharospasm associated with dystonia and benign essential blepharospasm**

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

☐ **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

- ☐ Yes ☐ No Do (did) the patient's headaches last 4 hours or longer on at least 8 days per month?
- ☐ Yes ☐ No Has the patient completed an adequate trial of **3** oral migraine preventative therapies coming from at least **2** of the following classes: antidepressants (e.g., amitriptyline, venlafaxine), or antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), or beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)?
  - ☐ Yes ☐ No Does the patient have a contraindication to any of the following classes: antidepressants (e.g., amitriptyline, venlafaxine), or antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate, valproate sodium), or beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)?
    Please indicate the number of classes the patient has a contraindication to:
    ☐ One class **or** ☐ Two classes:
    - ☐ Yes ☐ No Has the patient tried oral migraine preventative therapy from **1** of the following classes: antidepressants (e.g., amitriptyline, venlafaxine), antiepileptic drugs (AEDs) (e.g., divalproex sodium, topiramate valproate sodium), or beta-adrenergic blocking agents (e.g., metoprolol, propranolol, timolol, atenolol, nadolol)?
      How many days was the trial of each medication: ☐ 60 days or more ☐ Less than 60

    ☐ Three classes
  - Please indicate how many days was the trial of each medication: ☐ 60 days or more ☐ Less than 60 days

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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.

☐ **Chronic migraine prophylaxis (continued)**
- ☐ Yes ☐ No Does the patient have signs and symptoms consistent with chronic migraine criteria as defined by the International Headache Society (IHS)?

☐ **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 Has the patient undergone an endorectal pull through to treat the Hirschprung disease with internal sphincter achalasia?
- ☐ Yes ☐ No Is the patient refractory to laxative therapy?

☐ **Limb spasticity**

Please indicate which of the following applies to the patient: ☐ upper limb spasticity ☐ lower limb spasticity
- ☐ Yes ☐ No Is the spasticity either the primary diagnosis or a symptom of a condition causing limb spasticity?

☐ **Myofascial pain syndrome**

Please indicate which 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, 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, 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, palmar, and 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 oral 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 development is likely to occur?
- ☐ Yes ☐ No Is the patient likely to have spontaneous recovery?

☐ **Urinary incontinence associated 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])?

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.