



MEDICARE FORM

Botulinum Toxins Injectable Medication Precertification Request

Page 1 of 3

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

Virginia (HMO D-SNP):
FAX: 1-833-280-5224
PHONE: 1-855-463-0933

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

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:	
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:		Dispensing Provider/Pharmacy:	
<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: _____ PIN: _____	
<input type="checkbox"/> Administration code(s) (CPT): _____		TIN: _____ NPI: _____	
Address: _____			

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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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.

- 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
 - 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

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