Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Botox
(botulinum toxin type A)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ☐ Botox 50 unit vial
☐ Botox 100 unit vial ☐ Botox 200 unit vial Total Dose Requested: Frequency of Administration: Quantity:

List all muscles/sites that Botox will be injected at and list number of units being injected (e.g 30 units in trapezius muscle):

1._____**units into** _____ **6.**_____**units into** _____
2. _____**units into** _____ **7.**_____**units into** _____
3. _____**units into** _____ **8.**_____**units into** _____
4. _____**units into** _____ **9.**_____**units into** _____
5._____**units into** _____ **10.**_____**units into** _____

Duration of therapy: J-Code: CPT Code: ICD10:

Is this for new therapy or continuation of therapy? If your patient has already begun treatment with drug samples of Botox, please choose "new start of therapy". ☐ new therapy ☐ continuation of therapy

(if continuation of therapy) Has the patient had a beneficial/positive clinical response to therapy with this medication (for example, for migraines: a reduction in monthly migraine days or hours or reduction in days requiring acute migraine-specific treatment from the time that Botox was started)? Yes ☐ No ☐

(if continuation of therapy) Please provide past treatment dates/doses/frequency with Botox, documentation of clinical improvement and duration of benefit.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Please provide the diagnosis Botox is being used to treat and answer additional below questions as necessary.
Diagnosis: _____

Diagnoses are grouped by condition type (Neurological, Gastrointestinal, Exocrine, Ophthalmologic, and Urologic).

Neurologic Conditions

☐ **Blepharospasm**

****This diagnosis requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

**** If NEW TO Cigna or precertification is now required, all information must be provided.**

Does your patient have intermittent or sustained closure of the eyelids caused by involuntary contractions of the orbicularis oculi muscle? Yes ☐ No ☐
Is the requested drug prescribed by, or in consultation with, a neurologist or ophthalmologist? Yes ☐ No ☐

☐ **Cervical dystonia, including spasmodic torticollis**

****This diagnosis requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

**** If NEW TO Cigna or precertification is now required, all information must be provided.**

Does your patient have involuntary, simultaneous activation of agonist and antagonist muscles of the neck and shoulder (for example, sternocleidomastoid, splenius, levator scapulae, trapezius, semispinalis, scalene)? Yes ☐ No ☐
Does your patient have sustained head torsion and/or tilt with limited range of motion in the neck? Yes ☐ No ☐
Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist or a physical medicine and rehabilitation physician? Yes ☐ No ☐

☐ **Migraine Prevention**

****This diagnosis requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

**** If NEW TO Cigna or precertification is now required, all information must be provided.**

PRIOR to Botox, how many HEADACHE days per month is/was your patient experiencing? _____

PRIOR to Botox, how many hours per day do/did your patient's headaches last? _____

Has your patient been treated in the past with any of the following? (check all that apply)
☐ Yes, antiepileptic drugs
☐ Yes, antidepressants
☐ Yes, angiotensin receptor blockers (ARBs) or angiotensin converting enzyme inhibitors (ACEi's)
☐ Yes, beta blockers
☐ none of the above
(If yes) Please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug class checked, including any intolerances or adverse reactions your patient experienced.

(if alts tried) Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
☐ The patient tried 2 (or more) alternatives from different migraine prevention therapy classes for at least 8 weeks, but none of these drugs worked well enough.
☐ The patient tried at least one drug from ALL of the different migraine prevention therapy classes, but they did not tolerate any of them.
☐ The patient cannot try at least one drug from ANY of the different migraine prevention therapy classes because of a contraindication to each.
☐ Other

For each alternative that your patient didn't try, please provide details why they can't try that alternative [including: contraindication according to the FDA label; warnings per the prescribing information (labeling); disease characteristic or clinical factor the patient has]. _____

	Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist, neurologist, or otolaryngologist? Yes ☐ No ☐
☐	**Essential tremor (head, neck, hand, and voice)** Is the condition disabling? Yes ☐ No ☐ Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist or a physical medicine and rehabilitation physician? Yes ☐ No ☐
☐	**Focal Dystonias** Check all that apply: ☐ focal hand dystonia (for example, writer's cramp) ☐ adductor spasmodic dysphonia/laryngeal dystonia ☐ Jaw-closing oromandibular dystonia ☐ Meige's syndrome/cranial dystonia (blepharospasm with jaw-closing oromandibular cervical dystonia) Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist, an otolaryngologist, or a physical medicine and rehabilitation physician? Yes ☐ No ☐ [For focal hand dystonia] Is your patient's condition causing persistent pain or interfering with the ability to perform age-related activities of daily living? Yes ☐ No ☐
☐	**Spasm/palsies** Check all that apply: ☐ Hemifacial spasms ☐ Seventh cranial nerve palsy (Bells Palsy) ☐ Gaze palsies Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist or a physical medicine and rehabilitation physician? Yes ☐ No ☐ [For Gaze palsies] Is your patient experiencing persistent pain or vision impairment? Yes ☐ No ☐
☐	**Spastic Conditions** Check all that apply: ☐ Cerebral Palsy (including spastic equinus foot deformities) ☐ Cerebrovascular accident ☐ Localized adductor muscle spasticity in multiple sclerosis ☐ Spinal cord injury ☐ Traumatic brain injury ☐ Hereditary spastic paraplegia ☐ Upper limb spasticity (ULS) ☐ Lower limb spasticity (LLS) Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist or a physical medicine and rehabilitation physician? Yes ☐ No ☐ (if LLS) Is there documentation that your patient has had a significant decrease of function or ADLs* (for example, walking)? Yes ☐ No ☐ (if ULS) Is there documentation that your patient has had a significant decrease of function or ADLs* (for example, eating, washing)? Yes ☐ No ☐ *Activities of Daily Living
☐	**Other (please specify):**

Gastrointestinal Conditions

☐	**Chronic anal fissure** Has your patient failed conventional non-surgical treatment (for example, nitrate preparations, sitz baths, stool softeners, bulk-forming agents, diet modifications)? Yes ☐ No ☐ If *yes*, please specify which medications were tried. _____ Is the requested drug being prescribed by, or in consultation with, a gastroenterologist or a surgeon? Yes ☐ No ☐
	Hirschsprung disease Is Botox being used to treat obstructive symptoms due to a non-relaxing internal anal sphincter following surgery? Yes ☐ No ☐ Is the requested drug being prescribed by, or in consultation with, a gastroenterologist or a surgeon? Yes ☐ No ☐

☐

Primary esophageal achalasia

Does your patient have any of the following? (check all that apply)
☐ Concomitant illness and/or high risk for complications from myotomy or dilation
☐ Poor response to prior myotomy or dilation
☐ History of perforation caused by previous pneumatic dilatation
☐ Epiphrenic diverticulum
Is the requested drug being prescribed by, or in consultation with, a gastroenterologist? Yes ☐ No ☐

☐ **Other (please specify):**

Exocrine Conditions

☐

Glandular section

Check all that apply:
☐ cholinergic-mediated secretions associated with a fistula (for example, parotid gland, pharyngocutaneous)
☐ sialorrhea (excessive salivation) associated with cerebral palsy
☐ sialorrhea (excessive salivation) associated with parkinsonism
☐ other (please specify):

(if fistula) Is the requested drug being prescribed by, or in consultation with, a dermatologist, an endocrinologist, a neurologist or an otolaryngologist? Yes ☐ No ☐
(if sialorrhea) Is the requested drug being prescribed by, or in consultation with an endocrinologist, a neurologist, or an otolaryngologist? Yes ☐ No ☐
(if fistula) Has your patient had failure to pharmacotherapy (including anticholinergics)? Yes ☐ No ☐

(if sialorrhea) Is there documentation that your patient has failure/inadequate response, contraindication per FDA label, intolerance, or not a candidate for any of the following: (check all that apply)
☐ atropine ☐ glycopyrrolate ☐ scopolamine ☐ other (please specify): _____

☐

Hyperhidrosis

Check all that apply:
☐ primary axillary hyperhidrosis
☐ palmar hyperhidrosis
☐ gustatory sweating (Frey's syndrome, diabetic gustatory sweating)

Is the requested drug prescribed by, or in consultation with, a dermatologist, an endocrinologist, or a neurologist? Yes ☐ No ☐

<u>For primary axillary hyperhidrosis</u>:
Has your patient had failure to a prescription topical agent (aluminum chloride 20%)? Yes ☐ No ☐

Is this condition causing either of the following?
☐ significant interference with your patient's ability to perform age-related Activities of Daily Living
☐ persistent or chronic cutaneous conditions such as skin maceration, dermatitis, fungal infections, or secondary microbial conditions
☐ neither of the above

<u>For palmar hyperhidrosis</u>:
Has your patient had failure to a prescription topical agent (aluminum chloride 20%)? Yes ☐ No ☐

Has your patient had failure to systemic pharmacotherapy (Robinul/glycopyrrolate, Catapres/clonidine)? Yes ☐ No ☐
(if no) Does your patient have a clinical contraindication to systemic pharmacotherapy? Yes ☐ No ☐

Is this condition causing either of the following?
☐ significant interference with your patient's ability to perform age-related Activities of Daily Living
☐ persistent or chronic cutaneous conditions such as skin maceration, dermatitis, fungal infections, or secondary microbial conditions
☐ neither of the above

☐ **Other (please specify):**

Ophthalmologic Conditions

☐ **Strabismus disorders in adults**

Which of the following are present? (check all that apply)
☐ horizontal strabismus up to 50 prism diopters
☐ vertical strabismus
☐ persistent sixth nerve palsy of one month or longer duration

Is the requested drug prescribed by, or in consultation with, a neurologist or ophthalmologist? Yes ☐ No ☐

(if sixth nerve palsy) Does your patient have any of the following? (check all that apply)
☐ diplopia
☐ impaired depth perception
☐ impaired peripheral vision
☐ impaired ability to maintain fusion

☐ **Strabismus disorders in children**
Is the requested drug prescribed by, or in consultation with, a neurologist or ophthalmologist? Yes ☐ No ☐

☐ **Other (please specify):**

Urologic Conditions

Urinary incontinence due to detrusor overactivity
Urinary incontinence with overactive bladder (OAB)

☐ Does your patient have a history of multiple sclerosis (MS), spina bifida, spinal cord injury (SCI), intracranial lesion, or cerebrovascular accident (CVA)? Yes ☐ No ☐

(if yes) Has your patient had inadequate response or intolerance to ONE of the following: an anticholinergic medication (for example, darifenacin, fesoterodine, flavoxate, oxybutynin, solifenacin, tolterodine, trospium) OR a beta-3 adrenergic agonist (for example, Myrbetriq, Gemtesa)? Yes ☐ No ☐

(if no) Has your patient had inadequate response or intolerance to TWO agents from either of the following classes: anticholinergic medications (for example, darifenacin, fesoterodine, flavoxate, oxybutynin, solifenacin, tolterodine, trospium) OR beta-3 adrenergic agonists (for example, Myrbetriq, Gemtesa)? Yes ☐ No ☐

Is the requested drug being prescribed by, or in consultation with, a gynecologist or urologist? Yes ☐ No ☐

☐ **Interstitial cystitis/bladder pain syndrome**
Did your patient try and have inadequate response to the following?
☐ only second-line treatments, such as amitriptyline, cimetidine, hydroxyzine, pentosan polysulfate (Elmiron), dimethyl sulfoxide (DMSO), heparin, lidocaine
☐ only third-line treatments, such as cystoscopy with hydrodistention or treatment of Hunner's lesions (if found)
☐ both second-line and third-line therapies
☐ none of the above
Is the requested drug being prescribed by, or in consultation with, a gynecologist or urologist? Yes ☐ No ☐

☐ **Neurogenic Detrusor Overactivity (NDO)**

Has your patient had inadequate response or intolerance to either of the following: an anticholinergic medication OR a beta-3 adrenergic agonist? Yes ☐ No ☐

☐ **Other (please specify):**

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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