MEDICARE FORM
Botulinum Toxins Injectable Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

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

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For **Aetna Medicare Advantage** and **Allina Health Aetna Medicare** members send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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:
Provider Email:		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: _____
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 ☐ Daxxify
HCPCS Code: _____

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 Initiation Requests (clinical documentation required for all requests):

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

☐ Yes ☐ No Has the patient had prior therapy with the requested product within the last 365 days?

☐ No Has the patient had a trial and failure of any of the following? (if yes, select all that apply below)
- ☐ Botox (onabotulinumtoxinA) ☐ Xeomin (incobotulinumtoxinA)
- When was the member's trial and failure of the preferred drug? _____
- Please describe the nature of the failure of the preferred drug _____

☐ No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)
- ☐ Botox (onabotulinumtoxinA) ☐ Xeomin (incobotulinumtoxinA)
- When was the member's adverse reaction to the preferred drug? _____
- Please describe the nature of the adverse reaction to the preferred drug _____

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)
☐ Botox (onabotulinumtoxinA) ☐ Xeomin (incobotulinumtoxinA)?

_____

_____

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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.

For All Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is the prescribed therapy for cosmetic purposes (e.g., treatment of wrinkles or uncorrected congenital strabismus and no binocular fusion)?

Which of the following is the patient being treated for? *(Clinical documentation must support the symptoms specified)*

☐ Achalasia ☐ Auriculotemporal syndrome ☐ Backache ☐ Benign prostatic hyperplasia ☐ Bladder spasticity secondary to a spinal cord injury

☐ **Blepharospasm**
- ☐ Yes ☐ No Does the patient have blepharospasm associated with dystonia and benign essential blepharospasm
- ☐ Yes ☐ No Does the patient have blepharospasm associated with VII nerve disorders ach?

☐ **Cervicogenic headache**

☐ **Cervical dystonia** (e.g., torticollis)
- ☐ Yes ☐ No Is there abnormal placement of the head with limited range of motion in the neck?

☐ **Chronic anal fissure**

☐ **Chronic migraine prophylaxis**
- ☐ Yes ☐ No Does the patient have migraine headaches at least 15 days per month?

☐ **Chronic sialorrhea (excessive salivation)**

☐ **Detrusor (including neurogenic detrusor overactivity (NDO)) and sphincter dyssynergia**

☐ **Difficulty speaking after total laryngectomy**

☐ **Disorder of esophagus**

☐ **Epicondylitis**

☐ **Essential tremor**

☐ **Excessive salivation secondary to a disorder of the nervous system or advanced Parkinson's disease**

☐ **Excessive tear production**

☐ **Fibromyalgia**

☐ **Limb spasticity** (Choose all that apply)
- ☐ Upper limb spasticity OR ☐ Lower limb spasticity
- ☐ Yes ☐ No Is the spasticity the primary diagnosis or a symptom of a condition causing limb spasticity?

☐ **Gilles de la Tourette's syndrome**

☐ **Granuloma of vocal cords**
- ☐ Yes ☐ No Is the patient's condition refractory to conventional surgical and medical therapies (e.g., lansoprazole, rabeprazole)?

☐ **Hemifacial spasm**

☐ **Idiopathic trigeminal neuralgia**
- ☐ Yes ☐ No Is the requested drug for the treatment of refractory idiopathic trigeminal neuralgia?

☐ **Infantile esotropia**

☐ **Isolated oromandibular dystonia**

☐ **Larynx closure as adjunct to surgical procedure**

☐ **Myofascial pain syndrome**

☐ **Neuropathic pain secondary to spinal cord injury**

☐ **Oculomotor nerve injury (acute)**

☐ **Organic voice tremor**

☐ **Overactive bladder with urinary incontinence**

☐ **Palmar hyperhidrosis**

☐ **Pelvic floor dyssynergia**

☐ **Pharyngoesophageal segment spasm following total laryngectomy**

☐ **Primary axillary hyperhidrosis**

☐ **Spastic dysphonia**

☐ **Strabismus**

☐ **Stuttering**

☐ **Tardive dyskinesia**

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

For All Requests (clinical documentation required for all requests):

- ☐ **Temporomandibular joint disorder**
- ☐ **Tension-type headache**
- ☐ **Thoracic outlet syndrome**
- ☐ **Urinary incontinence associated with a neurologic condition (e.g., spinal cord injury, multiple sclerosis)**
- ☐ **Whiplash to the neck**
- ☐ **Other**

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Was the requested drug effective for treating the diagnosis or condition?

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.