Cigna®

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 currently taking for Migraine Headache Prevention) Is documentation being provided that if the patient is currently taking Botox for migraine headache prevention, the patient has had a significant clinical benefit from the medication as determined by the prescriber? Examples of significant clinical benefit include a reduction in the overall number of migraine days per month or a reduction in number of severe migraine days per month from the time that Botox was initiated. - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Yes ☐ No ☐

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 (including blepharospasm associated with dystonia, benign essential blepharospasm, seventh (VII) nerve disorders)**

Is documentation being provided that the patient has intermittent or sustained closure of the eyelids caused by involuntary contractions of the orbicularis oculi muscle? - Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Yes ☐ No ☐

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

☐ **Cervical dystonia, including spasmodic torticollis**

Is documentation being provided that the patient has a diagnosis of cervical dystonia?- Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Yes ☐ No ☐

Is documentation being provided that the patient has sustained head torsion and/or tilt with limited range of motion in the neck?- Please note: Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Medical documentation specific to your response to this question must be attached to this case or your request could be denied. Yes ☐ No ☐

Is the requested medication prescribed by, or in consultation with, a pain medicine specialist, neurologist, or physical medicine and rehabilitation physician? Yes ☐ No ☐

☐ **Migraine Headache Prevention**

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? _____

Per the information given above, PRIOR to initiation of Botox therapy, does/did the patient have 15 or more migraine headache days per month with each headache lasting four hours per day or longer? Yes ☐ No ☐

Is the requested medication being prescribed by, or in consultation with, a neurologist, or headache specialist? Yes ☐ No ☐

☐ **Essential tremor (head, neck, hand, and voice)**

Has the patient tried at least one other pharmacologic therapy for the treatment of tremors?
Notes: Examples of pharmacologic therapies for essential tremor include primidone, propranolol, atenolol, sotalol, alprazolam, gabapentin, topiramate. Yes ☐ No ☐

☐ **Focal Dystonias**

Check all that apply:
☐ Focal Upper Limb Dystonia (example: focal hand dystonia)
☐ Laryngeal Dystonia (Spasmodic Dysphonia)
☐ Oromandibular Dystonia (orofacial dystonia)

☐ **Hemifacial Spasm**

Limb spasticity

Which of the following best describes the patient's condition/reason for treatment?
☐ Lower limb spasticity (LLS)
☐ Upper limb spasticity (ULS)
☐ Both upper and lower limb spasticity

☐ **Other (please specify):**

Gastrointestinal Conditions

☐ **Achalasia**

☐ **Chronic anal fissure**

☐ **Other (please specify):**

Exocrine Conditions

☐ **Chronic Sialorrhea**

Hyperhidrosis

Check all that apply:
☐ primary axillary hyperhidrosis
☐ Primary Palmar/Plantar/Facial Hyperhidrosis
☐ gustatory sweating (Frey's syndrome)

For primary axillary hyperhidrosis:
Is the patient's hyperhidrosis significantly interfering with the ability to perform age-appropriate activities of daily living? Yes ☐ No ☐
Has the prescriber excluded secondary causes of hyperhidrosis? Yes ☐ No ☐

☐ Has the patient tried at least one topical prescription agent for axillary hyperhidrosis for at least 4 weeks and experienced inadequate efficacy or significant intolerance?
Notes: Examples of prescription topical agents for the treatment of axillary hyperhidrosis include Xerac AC (aluminum chloride 6.25% topical solution), Drysol (aluminum chloride 20% topical solution), Qbrexza (glycopyrronium cloth 2.4% for topical use), Sofdra (glycopyrronium 12.45% topical gel). Yes ☐ No ☐

For Primary Palmar/Plantar/Facial Hyperhidrosis:

Is the patient's hyperhidrosis significantly interfering with the ability to perform age-appropriate activities of daily living? Yes ☐ No ☐
Has the prescriber excluded secondary causes of hyperhidrosis? Yes ☐ No ☐

Has the patient tried at least one topical agent for axillary hyperhidrosis for at least 4 weeks and experienced inadequate efficacy or significant intolerance?
Notes: Examples of topical agents for the treatment of hyperhidrosis include topical aluminum chloride antiperspirants. Yes ☐ No ☐

☐ **Other (please specify):**

Ophthalmologic Conditions

☐ **Strabismus**

☐ **Other (please specify):**

Urologic Conditions

☐ **Overactive Bladder with Symptoms of Urge Urinary Incontinence, Urgency, and Frequency (Adult)**

Has the patient tried at least one other pharmacologic therapy for the treatment of overactive bladder (OAB)? Notes: Examples of other OAB pharmacologic therapies include a beta-3 adrenergic agonist or an anticholinergic medication. Yes ☐ No ☐

☐ **Urinary Incontinence Due to Detrusor Overactivity Associated with a Neurological Condition (Adult)**

Has the patient tried at least one other pharmacologic therapy for the treatment of urinary incontinence?
Notes: Examples of other pharmacologic therapies for urinary incontinence include a beta-3 adrenergic agonist or an anticholinergic medication. Yes ☐ No ☐

☐ **Neurogenic Detrusor Overactivity (NDO), Pediatric**

Has the patient tried at least one other pharmacologic therapy for the treatment of neurogenic detrusor overactivity (NDO)? Notes: Examples of other NDO pharmacologic therapies include a beta-3 adrenergic agonist or an anticholinergic medication.
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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