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

Daxxify
(DaxibotulinumtoxinA-lanm)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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:
☐ Daxxify 100 unit vial

Dose: Frequency of therapy: Duration of therapy:

List all muscles/sites that Daxxify 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 _____

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

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 your patient a candidate for home infusion? Yes ☐ No ☐
Does the physician have an in-office infusion site? Yes ☐ No ☐

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

What is the patient's diagnosis or reason for treatment?
☐ Cervical Dystonia (spasmodic torticollis)
☐ Cosmetic Use
☐ other (please specify):

Clinical Information:

****This drug requires supportive documentation for all answers, including chart notes, lab/test results. Supportive documentation for all answers must be attached with this request.**

(if Cervical Dystonia) Is documentation being provided that the patient has a diagnosis of cervical dystonia (spasmodic torticollis)? - Please note: Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, 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

(if Cervical Dystonia) 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 results, medical test results, claims records, prescription receipts, 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

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

Additional Information: *(Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket.]:*

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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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