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 Cosmetic 50 unit vial
☐ Botox Cosmetic 100 unit vial
☐ Botox 100 unit vial
☐ Botox 200 unit vial

Total Dose Requested: Frequency of Administration: Quantity:

Duration of therapy: J-Code: ICD10:

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:

CPT Code:

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

What is the indication or diagnosis?
☐ Blepharospasm (Please Note: This includes blepharospasm associated with dystonia, benign essential blepharospasm, seventh (VII) nerve disorders.)
☐ Strabismus (Please Note: Common types of strabismus include esotropia, exotropia, hypertropia, hypotropia.)
☐ Cervical dystonia (Please Note: Cervical dystonia is also referred to as spasmodic torticollis.)
☐ Hyperhidrosis (primary axillary)
☐ Hyperhidrosis, gustatory (Please Note: Gustatory hyperhidrosis is also referred to as Frey's Syndrome.)
☐ Hyperhidrosis (primary palmar/plantar/craniofacial)
☐ Chronic migraine headache prevention
☐ Spasticity, limb(s)
☐ Adult overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency (Please Note: For treatment of adult urinary incontinence due to detrusor overactivity associated with a neurological condition, see additional diagnosis.)

☐ Adult urinary incontinence due to detrusor overactivity associated with a neurological condition (Please Note: Examples of neurological conditions include spinal cord injury, multiple sclerosis, or spina bifida. For treatment of adult overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency, see additional diagnosis. For treatment of pediatric neurogenic detrusor overactivity (NDO), see additional diagnosis.)
☐ Pediatric neurogenic detrusor overactivity (NDO) (Please Note: For treatment of adult urinary incontinence due to detrusor overactivity associated with a neurological condition, see additional diagnosis.)
☐ Achalasia (Please Note: Achalasia is also referred to as esophageal achalasia or achalasia cardia.)
☐ Anal fissure, chronic
☐ Dystonia, focal upper limb (Please Note: An example of focal upper limb dystonia is focal hand dystonia.)
☐ Essential tremor
☐ Hemifacial spasm
☐ Laryngeal dystonia (spasmodic dysphonia)
☐ Oromandibular dystonia (Please Note: Oromandibular dystonia is also referred to as orofacial dystonia.)
☐ Sialorrhea, chronic
☐ Cosmetic use (Please Note: Examples of cosmetic uses include facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platysmal bands, rejuvenation of the periorbital region.)
☐ Gastroparesis
☐ All other indications not listed

Neurologic Conditions

☐ **For 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. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. Yes ☐ No ☐

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

☐ **For Cervical dystonia, including spasmodic torticollis**

Is documentation being provided that the patient has a diagnosis of cervical dystonia? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. 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: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. 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 ☐

☐ **For Chronic Migraine Headache Prevention**

Does the patient have greater than or equal to 15 headache days per month with headache lasting 4 hours per day or longer (prior to initiating a migraine-preventive medication)? Yes ☐ No ☐

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

Is the patient currently taking Botox for chronic migraine headache prevention? Yes ☐ No ☐

Is documentation being provided that 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: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. Yes ☐ No ☐

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

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

Exocrine Conditions

☐ **For Hyperhidrosis (primary axillary):**

Is hyperhidrosis significantly interfering with the ability to perform age-appropriate activities of daily living? Yes ☐ No ☐

Has the prescriber excluded secondary causes of hyperhidrosis?

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? Please Note: 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 Hyperhidrosis (Primary Palmar/Plantar/Craniofacial)**

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? Please Notes: Examples of topical agents for the treatment of hyperhidrosis include topical aluminum chloride antiperspirants. Yes ☐ No ☐

Urologic Conditions

☐ **For Adult Overactive Bladder with Symptoms of Urge Urinary Incontinence, Urgency, and Frequency:**

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

☐ **For Adult Urinary Incontinence Due to Detrusor Overactivity Associated with a Neurological Condition:**

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

☐ **For Pediatric Neurogenic Detrusor Overactivity (NDO):**

Has the patient tried at least one other pharmacologic therapy for the treatment of neurogenic detrusor overactivity (NDO)? Please Note: Examples of other NDO pharmacologic therapies include a beta-3 adrenergic agonist or an anticholinergic medication. Yes ☐ No ☐

☐ **Additional Pertinent Information:**

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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