



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: <input type="checkbox"/> Standard <input type="checkbox"/> 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: <input type="checkbox"/> Daxxify 100 unit vial Dose: _____ Frequency of therapy: _____ Duration of therapy: _____					
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): _____ **Cigna's nationally preferred specialty pharmacy					
<i>**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</i>					
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 <input type="checkbox"/> No <input type="checkbox"/> Does the physician have an in-office infusion site? Yes <input type="checkbox"/> No <input type="checkbox"/>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
What is the indication or diagnosis? <input type="checkbox"/> Cervical Dystonia – Note: Cervical dystonia is also known as spasmodic torticollis. <input type="checkbox"/> Cosmetic Use Note: Examples of cosmetic uses include facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platysmal bands, or rejuvenation of the periorbital region. <input type="checkbox"/> All other indications or diagnoses					
Clinical Information: (if Cervical Dystonia) Is documentation being provided that confirms 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 could be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. <input type="checkbox"/> Yes <input type="checkbox"/> 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: Medical documentation specific to your response must be attached to this case or your request could be denied. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information. Yes No

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

Additional 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:** _____

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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