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

Dysport and Xeomin

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: ☐ Dysport ☐ Xeomin

Total Dose Requested: Frequency of Administration: Quantity:

Duration of therapy: J-Code: CPT Code: ICD10:

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

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):

Diagnosis related to use:
☐ Blepharospasm (including blepharospasm associated with dystonia, benign essential blepharospasm, seventh (VII) nerve disorders)
☐ cervical dystonia(Please Note: Cervical dystonia is also referred to as spasmodic torticollis)
☐ Anal fissure, chronic
☐ Sialorrhea, chronic
☐ Cosmetic Use (Examples of cosmetic uses include facial rhytides, frown lines, glabellar wrinkling, horizontal neck rhytides, mid and lower face and neck rejuvenation, platsymal bands, or rejuvenation of the periorbital region)
☐ Hemifacial Spasm
☐ Spasticity, limb(s)
☐ Oromandibular Dystonia - Please Note: Oromandibular dystonia is also referred to as orofacial dystonia.
☐ other

If blepharospasm:

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: 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, prescription claims records, prescription receipts, and/or other information. Yes ☐ No ☐

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

If cervical dystonia/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, prescription claims records, prescription receipts, and/or other 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, prescription claims records, prescription receipts, and/or other 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 ☐

If Limb(s) 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

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:**____________________

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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