



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 continued therapy? If your patient has already begun treatment with drug samples of Botox, please choose "new start of therapy". new therapy continued therapy
 (if continued therapy) Is your patient having a beneficial clinical response to Botox therapy? Yes No
 (if continued therapy) Please provide past treatment dates/doses/frequency with Botox, documentation of clinical improvement and duration of benefit.

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 |

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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

****This diagnosis requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

**** If NEW TO Cigna or precertification is now required, all information must be provided.**

Does your patient have intermittent or sustained closure of the eyelids caused by involuntary contractions of the orbicularis oculi muscle? Yes No
Is the requested drug prescribed by, or in consultation with, a neurologist or ophthalmologist? Yes No

Cervical dystonia, including spasmodic torticollis

****This diagnosis requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

**** If NEW TO Cigna or precertification is now required, all information must be provided.**

Does your patient have involuntary, simultaneous activation of agonist and antagonist muscles of the neck and shoulder (for example, sternocleidomastoid, splenius, levator scapulae, trapezius, semispinalis, scalene)? Yes No
Does your patient have sustained head torsion and/or tilt with limited range of motion in the neck? Yes No
Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist or a physical medicine and rehabilitation physician? Yes No

Migraine Prevention

****This diagnosis requires supportive documentation (i.e. chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request.**

**** If NEW TO Cigna or precertification is now required, all information must be provided.**

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? _____

(if continued therapy) Has your patient had a reduction in monthly migraine days or hours? Yes No
(if no) Has your patient had a reduction in days requiring acute migraine-specific treatment? Yes No

Has your patient been treated in the past with any of the following? (check all that apply)

- antiepileptic drugs (divalproex, sodium valproate, topiramate)
- antidepressants (amitriptyline, venlafaxine)
- beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
- none of the above

Please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug checked.

Is there a documented contraindication per FDA label OR reason your patient is not a candidate for any of the following? (check all that apply)

- antiepileptic drugs (divalproex, sodium valproate, topiramate)
- antidepressants (amitriptyline, venlafaxine)
- beta blockers (atenolol, metoprolol, nadolol, propranolol, timolol)
- none of the above

Please include drug name and the documented reasons your patient is unable to use that drug/drug class.

While taking Botox, will your patient also use a CGRP inhibitor (Aimovig, Ajovy, Emgality, Vyepti) for preventative treatment of chronic migraine during the same time period? Yes or Possibly No Unknown

(if Yes or Possibly) Prior to starting combination therapy with a CGRP, did/does your patient continue to experience 4 or more migraine headache days per month? Yes No

(if Yes or Possibly) Prior to starting combination therapy did your patient try either of the following:

- A minimum 3 month trial of Aimovig, Ajovy, Emgality, or Vyepti
- A minimum 6 month trial (2 injection cycles) of onabotulinumtoxinA (Botox)
- No or Unknown

Please provide details of previous medications tried, results, and provide clinical rationale for concurrent use of these

	drugs.
	Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist or a neurologist? Yes <input type="checkbox"/> No <input type="checkbox"/>

Essential tremor (head, neck, hand, and voice)	
<input type="checkbox"/>	Is the condition disabling? Yes <input type="checkbox"/> No <input type="checkbox"/> Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist or a physical medicine and rehabilitation physician? Yes <input type="checkbox"/> No <input type="checkbox"/>

Focal Dystonias	
<input type="checkbox"/>	Check all that apply: <input type="checkbox"/> focal hand dystonia (for example, writer's cramp) <input type="checkbox"/> adductor spasmodic dysphonia/laryngeal dystonia <input type="checkbox"/> Jaw-closing oromandibular dystonia <input type="checkbox"/> Meige's syndrome/cranial dystonia (blepharospasm with jaw-closing oromandibular cervical dystonia) Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist, an otolaryngologist, or a physical medicine and rehabilitation physician? Yes <input type="checkbox"/> No <input type="checkbox"/> [For focal hand dystonia] Is your patient's condition causing persistent pain or interfering with the ability to perform age-related activities of daily living? Yes <input type="checkbox"/> No <input type="checkbox"/>

Spasm/palsies	
<input type="checkbox"/>	Check all that apply: <input type="checkbox"/> Hemifacial spasms <input type="checkbox"/> Seventh cranial nerve palsy (Bells Palsy) <input type="checkbox"/> Gaze palsies Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist or a physical medicine and rehabilitation physician? Yes <input type="checkbox"/> No <input type="checkbox"/> [For Gaze palsies] Is your patient experiencing persistent pain or vision impairment? Yes <input type="checkbox"/> No <input type="checkbox"/>

Spastic Conditions	
<input type="checkbox"/>	Check all that apply: <input type="checkbox"/> Cerebral Palsy (including spastic equinus foot deformities) <input type="checkbox"/> Cerebrovascular accident <input type="checkbox"/> Localized adductor muscle spasticity in multiple sclerosis <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Hereditary spastic paraplegia <input type="checkbox"/> Upper limb spasticity (ULS) <input type="checkbox"/> Lower limb spasticity (LLS) Is the requested drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist or a physical medicine and rehabilitation physician? Yes <input type="checkbox"/> No <input type="checkbox"/> (if LLS) Is there documentation that your patient has had a significant decrease of function or ADLs* (for example, walking)? Yes <input type="checkbox"/> No <input type="checkbox"/> (if ULS) Is there documentation that your patient has had a significant decrease of function or ADLs* (for example, eating, washing)? Yes <input type="checkbox"/> No <input type="checkbox"/> *Activities of Daily Living

<input type="checkbox"/>	Other (please specify):
--------------------------	--------------------------------

Gastrointestinal Conditions

Chronic anal fissure	
<input type="checkbox"/>	Has your patient failed conventional non-surgical treatment (for example, nitrate preparations, sitz baths, stool softeners, bulk-forming agents, diet modifications)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please specify which medications were tried. _____ Is the requested drug being prescribed by, or in consultation with, a gastroenterologist or a surgeon? Yes <input type="checkbox"/> No <input type="checkbox"/>

	Hirschsprung disease
	Is Botox being used to treat obstructive symptoms due to a non-relaxing internal anal sphincter following surgery? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Is the requested drug being prescribed by, or in consultation with, a gastroenterologist or a surgeon? Yes <input type="checkbox"/> No <input type="checkbox"/>

	Primary esophageal achalasia
<input type="checkbox"/>	Does your patient have any of the following? (check all that apply) <input type="checkbox"/> Concomitant illness and/or high risk for complications from myotomy or dilation <input type="checkbox"/> Poor response to prior myotomy or dilation <input type="checkbox"/> History of perforation caused by previous pneumatic dilatation <input type="checkbox"/> Epiphrenic diverticulum Is the requested drug being prescribed by, or in consultation with, a gastroenterologist? Yes <input type="checkbox"/> No <input type="checkbox"/>

<input type="checkbox"/>	Other (please specify):
--------------------------	--------------------------------

Exocrine Conditions

	Glandular section
<input type="checkbox"/>	Check all that apply: <input type="checkbox"/> cholinergic-mediated secretions associated with a fistula (for example, parotid gland, pharyngocutaneous) <input type="checkbox"/> sialorrhea (excessive salivation) associated with cerebral palsy <input type="checkbox"/> sialorrhea (excessive salivation) associated with parkinsonism <input type="checkbox"/> other (please specify): _____ (if fistula) Is the requested drug being prescribed by, or in consultation with, a dermatologist, an endocrinologist, a neurologist or an otolaryngologist? Yes <input type="checkbox"/> No <input type="checkbox"/> (if sialorrhea) Is the requested drug being prescribed by, or in consultation with an endocrinologist, a neurologist, or an otolaryngologist? Yes <input type="checkbox"/> No <input type="checkbox"/> (if fistula) Has your patient had failure to pharmacotherapy (including anticholinergics)? Yes <input type="checkbox"/> No <input type="checkbox"/> (if sialorrhea) Is there documentation that your patient has failure/inadequate response, contraindication per FDA label, intolerance, or not a candidate for any of the following: (check all that apply) <input type="checkbox"/> atropine <input type="checkbox"/> glycopyrrolate <input type="checkbox"/> scopolamine <input type="checkbox"/> other (please specify): _____

	Hyperhidrosis
<input type="checkbox"/>	Check all that apply: <input type="checkbox"/> primary axillary hyperhidrosis <input type="checkbox"/> palmar hyperhidrosis <input type="checkbox"/> gustatory sweating (Frey's syndrome, diabetic gustatory sweating) Is the requested drug prescribed by, or in consultation with, a dermatologist, an endocrinologist, or a neurologist? Yes <input type="checkbox"/> No <input type="checkbox"/> <u>For primary axillary hyperhidrosis:</u> Has your patient had failure to a prescription topical agent (aluminum chloride 20%)? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this condition causing either of the following? <input type="checkbox"/> significant interference with your patient's ability to perform age-related Activities of Daily Living <input type="checkbox"/> persistent or chronic cutaneous conditions such as skin maceration, dermatitis, fungal infections, or secondary microbial conditions <input type="checkbox"/> neither of the above <u>For palmar hyperhidrosis:</u> Has your patient had failure to a prescription topical agent (aluminum chloride 20%)? Yes <input type="checkbox"/> No <input type="checkbox"/> Has your patient had failure to systemic pharmacotherapy (Robinul/glycopyrrolate, Catapres/clonidine)? Yes <input type="checkbox"/> No <input type="checkbox"/> (if no) Does your patient have a clinical contraindication to systemic pharmacotherapy? Yes <input type="checkbox"/> No <input type="checkbox"/> Is this condition causing either of the following? <input type="checkbox"/> significant interference with your patient's ability to perform age-related Activities of Daily Living <input type="checkbox"/> persistent or chronic cutaneous conditions such as skin maceration, dermatitis, fungal infections, or secondary microbial conditions <input type="checkbox"/> neither of the above

<input type="checkbox"/>	Other (please specify):
--------------------------	--------------------------------

Ophthalmologic Conditions

Strabismus disorders in adults

Which of the following are present? (check all that apply)

- horizontal strabismus up to 50 prism diopters
- vertical strabismus
- persistent sixth nerve palsy of one month or longer duration

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

(if sixth nerve palsy) Does your patient have any of the following? (check all that apply)

- diplopia
- impaired depth perception
- impaired peripheral vision
- impaired ability to maintain fusion

Strabismus disorders in children
Is the requested drug prescribed by, or in consultation with, a neurologist or ophthalmologist? Yes No

Other (please specify):

Urologic Conditions

Urinary incontinence due to detrusor overactivity Urinary incontinence with overactive bladder (OAB)

Does your patient have a history of multiple sclerosis (MS), spina bifida, spinal cord injury (SCI), intracranial lesion, or cerebrovascular accident (CVA)? Yes No

(if yes) Has your patient had inadequate response or intolerance to ONE of the following: an anticholinergic medication (for example, darifenacin, fesoterodine, flavoxate, oxybutynin, solifenacin, tolterodine, trospium) OR a beta-3 adrenergic agonist (for example, Myrbetriq, Gemtesa)? Yes No

(if no) Has your patient had inadequate response or intolerance to TWO agents from either of the following classes: anticholinergic medications (for example, darifenacin, fesoterodine, flavoxate, oxybutynin, solifenacin, tolterodine, trospium) OR beta-3 adrenergic agonists (for example, Myrbetriq, Gemtesa)? Yes No

Is the requested drug being prescribed by, or in consultation with, a gynecologist or urologist? Yes No

Interstitial cystitis/bladder pain syndrome

Did your patient try and have inadequate response to the following?

- only second-line treatments, such as amitriptyline, cimetidine, hydroxyzine, pentosan polysulfate (Elmiron), dimethyl sulfoxide (DMSO), heparin, lidocaine
- only third-line treatments, such as cystoscopy with hydrodistention or treatment of Hunner's lesions (if found)
- both second-line and third-line therapies
- none of the above

Is the requested drug being prescribed by, or in consultation with, a gynecologist or urologist? 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:** _____

Save Time! Submit Online at: www.covermy meds.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.

v042121

"Cigna" is a registered service mark, and the "Tree of Life" logo is a service mark, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include, for example, Cigna Health and Life Insurance Company and Cigna Health Management, Inc. Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005