



MEDICARE FORM

Botulinum Toxins Injectable Medication Precertification Request

Page 1 of 3

(All fields must be completed and legible for precertification review.)

For New Jersey HMO D-SNP:

FAX: 1-833-322-0034

PHONE: 1-844-362-0934

For other lines of business:

Please use other form.

Note: Botox and Myobloc are non-preferred. The preferred products are Dysport and Xeomin.

Please indicate: Start of treatment: Start date / / Continuation of therapy, Date of last treatment / /

Precertification Requested By: Phone: Fax:

A. PATIENT INFORMATION

Form section A: Patient Information. Fields include First Name, Last Name, DOB, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, Email, Patient Current Weight, Patient Height, Allergies.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Aetna Member ID #, Group #, Insured, Does patient have other coverage?, Carrier Name, Insured.

C. PRESCRIBER INFORMATION

Form section C: Prescriber Information. Fields include First Name, Last Name, (Check One) M.D., D.O., N.P., P.A., Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Provider Email, Office Contact Name, Phone.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Divided into Place of Administration and Dispensing Provider/Pharmacy. Includes checkboxes for Self-administered, Physician's Office, Home, Outpatient Infusion Center, Home Infusion Center, Administration code(s) (CPT), and various contact details.

E. PRODUCT INFORMATION

Form section E: Product Information. Fields include Request is for (Botox, Dysport, Myobloc, Xeomin), Dose, Frequency, HCPCS Code.

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Form section F: Diagnosis Information. Fields include Primary ICD Code, Secondary ICD Code, Other ICD Code.

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

Form section G: Clinical Information. Includes Note: Botox and Myobloc are non-preferred. The preferred products are Dysport and Xeomin. Contains questions about prior therapy, trial and failure, and reasons for not using preferred products.

Which of the following is the patient being treated for? (Clinical documentation must support the symptoms specified)

Form section G (continued): Clinical Information. Includes checkboxes for Blepharospasm, Cervical dystonia, and Chronic anal fissure, with detailed sub-questions and instructions.

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Patient First Name Patient Last Name Patient Phone Patient DOB

G. CLINICAL INFORMATION (continued) - Required clinical information must be completed in its entirety for all precertification requests.

- criopharyngeal dysfunction
esophageal achalasia
first bite syndrome
facial myokymia and trismus
focal dystonias
focal hand dystonias
hirschsprung's disease
hyperhidrosis
laryngeal spasm
limb spasticity
medically refractory upper extremity tremor
migraines

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Patient First Name Patient Last Name Patient Phone Patient DOB

G. CLINICAL INFORMATION (continued) - Required clinical information must be completed in its entirety for all precertification requests.

For migraine continuation requests:
[] Yes [] No Has the frequency of migraine headaches been reduced by at least 7 days per month by the end of the initial trial?
[] Yes [] No Has the duration of the migraine headaches been reduced by at least 100 total hours per month by the end of the initial trial?
[] Neurogenic detrusor over activity - [] Yes [] No Is the condition resulting from multiple sclerosis, spinal cord injury, or other neurologic condition?
If yes, please select diagnosis: [] Multiple Sclerosis [] spinal cord injury [] other neurologic condition - specify:
Please check all that apply: [] Detrusor over activity confirmed by urodynamic testing [] Documented failure of behavioral therapy
[] Failure/intolerance to at least one adequately titrated anticholinergic medication (e.g. oxybutynin chloride, trospium chloride)
Please indicate the name and date range tried: Name: Date:
[] Orofacial tardive dyskinesia - [] Yes [] No Have conventional therapies have been tried and failed (e.g., benzodiazepines, clozapine, tetrabenazine)?
[] Documented failure/intolerance to an OTC bladder medication (oxybutynin transdermal patch (Oxytrol for Women).
Please indicate the medications tried: Medication #1: Date:
Medication #2: Date:
[] Overactive bladder
[] Yes [] No Will prophylactic antibiotics be administered 1-3 days prior to treatment, on the treatment day, and 1-3 days post-treatment?
[] Yes [] No Will the requested medication be used in combination with other anticholinergic agents?
Please check all that apply:
[] Symptoms of urinary incontinence, urgency, and frequency
[] Documented behavioral therapy failure
[] Currently have an acute urinary tract infection or acute urinary retention
[] Documented failure/intolerance to adequately titrated overactive bladder medications (e.g., oxybutynin, trospium, Myrbetriq, Vesicare)
Please provide the name and date ranges: Medication #1: Date:
Medication #2: Date:
Medication #3: Date:
[] Painful Bruxism
[] Palatal Myoclonus with disabling symptoms (e.g., objective, intrusive clicking tinnitus)
[] Post-facial (7th cranial) nerve palsy synkinesis (hemifacial spasms)
[] Yes [] No Are symptoms characterized by sudden, unilateral, synchronous contractions of muscles innervated by the facial nerve?
[] Post-parotidectomy sialocele
[] Yes [] No Has the patient failed conservative management?
Please identify which type of conservative management treated failed: [] Antibiotic
Please provide name of antibiotic and date ranged used:
Medication #1: Date:
[] Pressure dressing
[] Serial percutaneous needle aspiration
[] Other treatment type- specify:
[] Ptyalism/sialorrhea (excessive secretion of saliva, drooling) - Please check all that apply:
[] Refractory to pharmacotherapy (including anticholinergics)
[] Documentation of medically significant complications of sialorrhea, such as chronic skin maceration or infections that cannot be controlled with topical treatments or hygiene
[] Strabismus (esotropia horizontal for deviations < 50 prism diopters, vertical strabismus or persistent cranial nerve VI palsies (including gaze palsies accompanying diseases, such as neuromyelitis optica, Schilder's disease) - Please check all that apply:
[] Uncorrected congenital strabismus or no binocular fusion [] Previously failed corrective surgery [] Spontaneous recovery of strabismus unlikely
[] Medication being prescribed as an alternative to surgery [] Interference with normal visual system development is likely to occur
[] Other Condition - Please attach rationale for use

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): Date: / /

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.