Prior Authorization

AETNA BETTER HEALTH ILLINIOS

Botulinum Toxins (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Botulinum Toxins (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Botox (onabotulinumtoxinA) Dysport (abobotulinumtoxinA)

Myobloc (rimabotulinumtoxinB) Xeomin (incobotulinumtoxinA)

Other, Please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for cosmetic purposes? Y N

   [If yes, no further questions.]

2. Is the requested drug prescribed by a specialist based on the condition treated? (e.g., neurologist, headache specialist, physical medicine, ophthalmologist, dermatologist) Y N

   Please indicate specialty:_____

   [If no, no further questions.]

3. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 5.]

4. Has the patient had a response to treatment? Y N

   [If no, no further questions.]

   [If yes, skip to question 50.]

5. Is this a request for Botox for treatment of cervical dystonia? Y N

   [If yes, skip to question 48.]

6. Is this a request for Dysport, Myobloc, or Xeomin for treatment of cervical dystonia? Y N

   [If yes, skip to question 49.]

7. Is this a request for Botox for treatment of blepharospasm? Y N

   [If yes, skip to question 47.]

8. Is this a request for Xeomin for treatment of blepharospasm? Y N

   [If no, skip to question 10.]

9. Has the patient previously been treated with onabotulinumtoxinA (Botox)? Y N

   [If yes, skip to question 49.]

   [If no, then no further questions]

10. Is this a request for Botox, Xeomin or Dysport for the treatment of Chronic Limb Spasticity? Y N

    [If no, skip to question 17.]

11. Is the spasticity due to ONE of the following: A) hereditary spastic paraplegia, B) spastic hemiplegia due to stroke, traumatic brain or spinal cord injury, or C) multiple sclerosis or other demyelinating disease? Y N

    [If no, then no further questions.]

12. Has the patient had a trial and failure of baclofen AND at least 1 additional formulary muscle relaxant such as dantrolene or tizanidine? Y N

    List medications tried and reason for failure:

_____

[If no, then no further questions.]

13. Has the patient tried physical and/or occupational therapy? Y N

[If no, then no further questions.]

14. Is there evidence that the abnormal muscle tone is either interfering with functional ability OR is expected to result in joint contracture? Y N

[If no, then no further questions.]

15. Is this a request for Dysport for the treatment of lower limb spasticity? Y N

[If no, skip to question 49.]

16. Is the patient at least 2 years old? Y N

[If no, then no further questions.]

[If yes, skip to question 50.]

17. Is this a request for Botox for treatment of sialorrhea (excessive drooling) associated with neurological disorders (i.e., Parkinson's disease, ALS, cerebral palsy)? Y N

[If no, skip to question 19.]

18. Is the patient at least 3 years old? Y N

[If no, no further questions.]

[If yes, skip to question 21.]

19. Is this a request for Myobloc for treatment of sialorrhea (excessive drooling) associated with neurological disorders (i.e., Parkinson's disease, ALS, cerebral palsy)? Y N

[If no, skip to question 23.]

20. Is the patient at least 18 years old? Y N

[If no, then no further questions.]

21. Has the patient had a trial and failure of glycopyrrolate and benztropine? Y N

List medications tried and reason for failure:

_____

[If no, no further questions.] Y N

22. Does the patient have medically significant complications from the sialorrhea (i.e., chronic skin maceration or uncontrolled infections)? Y N

    [If yes, skip to question 50.]

    [If no, then no further questions.]

23. Is this a request for Myobloc or Xeomin? Y N

    [If yes, then no further questions.]

24. Is this a request for Botox for treatment of strabismus in a patient with deviations of less than 50 prism diopters? Y N

    [If yes, skip to question 47.]

25. Is this a request for Botox for treatment of hemifacial spasm? Y N

    [If yes, skip to question 49.]

26. Is this a request for Botox for treatment of chronic migraines? Y N

    [If no, skip to question 29.]

27. Does the patient meet ALL of the following criteria: A) Migraine frequency is at least 15 days or more in a 30-day period, B) Headaches last 4 hours or longer, and C) Migraine frequency and severity has been present for at least 3 months Y N

    [If no, then no further questions.]

28. Has the patient had a trial and failure (less than 50% reduction in migraine frequency after at least 2 months duration) or intolerance to at least 1 formulary medication from at least 2 of the following first line drug classes used for migraine prophylaxis: A) Beta-blocker: propranolol, B) Anticonvulsant: valproic acid, divalproex, topiramate, C) Antidepressants: amitriptyline Y N

    List medications tried and reason for failure:

    _____

    [If no, then no further questions.]

    [If yes, skip to question 49.]

29. Is this a request for Botox for the treatment of neurogenic bladder? Y N

[If no, skip to question 32.]

30. Has the patient had a trial and failure of 2 formulary urinary anticholinergics (i.e., oxybutynin, trospium, tolterodine)? Y N

    List medications tried and reason for failure:

    _____

    [If no, then no further questions.]

31. Has the patient had a trial and failure of behavioral therapy (i.e., bladder training or pelvic floor exercises)? Y N

    [If no, then no further questions.]

    [If yes, skip to question 49.]

32. Is this a request for Botox for the treatment of overactive bladder? Y N

    [If no, skip to question 35.]

33. Has the patient had a trial and failure of 3 formulary urinary anticholinergics (i.e., oxybutynin, trospium, tolterodine)? Y N

    List medications tried and reason for failure:

    _____

    [If no, then no further questions.]

34. Has the patient had a trial and failure of behavioral therapy (i.e., bladder training or pelvic floor exercises)? Y N

    [If no, then no further questions.]

    [If yes, skip to question 49.]

35. Is this a request for Botox for the treatment of achalasia? Y N

    [If no, skip to question 38.]

36. Does the patient meet ONE of the following: A) Patient remains symptomatic despite surgical myotomy or pneumatic dilation, B) Patient is not a candidate for surgical myotomy or pneumatic dilation or refuses procedure(s), or C) Patient presents with atypical achalasia symptoms and Botox is needed to help guide therapy and/or confirm diagnosis Y N

    Please indicate which:

    _____

[If no, then no further questions]

37. Has malignancy at the esophagogastric junction been ruled out by endoscopic evaluation? Y N

    [If no, then no further questions.]

    [If yes, skip to question 49.]

38. Is this a request for Botox for treatment of chronic anal fissures? Y N

    [If no, skip to question 41.]

39. Has the patient had a trial and failure of nitroglycerin ointment 0.4% (Rectiv) for at least 3 weeks AND either bulk fiber supplements, stool softeners, or sitz baths for at least 1 month? Y N

    List treatments tried and reason for failure:
    _____

    [If no, then no further questions.]

40. Has Crohn's disease been ruled out? Y N

    [If no, then no further questions.]

    [If yes, skip to question 49.]

41. Is this a request for Botox for treatment of severe primary axillary hyperhidrosis? Y N

    [If no, skip to question 45.]

42. Does the patient have medical complications such as skin maceration with secondary skin infections? Y N

    [If no, no further questions.]

43. Does the patient have a score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS)? Y N

    [If no, then no further questions.]

44. Has the patient had a trial and failure of a 2 month trial of topical aluminum chloride 20%? Y N

    [If no, no further questions.]

    [If yes, skip to question 49.]

45. Is this a request for Botox or Dysport for the chronic management of focal spasticity or equinus gait (tiptoeing) in a pediatric patient (2-18 years of age) with cerebral palsy? Y N

    [If no, then no further questions.]

46. Will the patient be enrolled in, or is the patient currently being managed with, occupational therapy? Y N

    [If yes, skip to question 50.]

    [If no, then no further questions.]

47. Is the patient at least 12 years old? Y N

    [If yes, skip to question 50.]

    [If no, then no further questions.]

48. Is the patient at least 16 years old? Y N

    [If yes, skip to question 50.]

    [If no, then no further questions.]

49. Is the patient at least 18 years old? Y N

    [If no, then no further questions.]

50. Are treatments scheduled at least 12 weeks apart? Y N

    [If no, no further questions.]

51. Is the dose prescribed within the FDA-approved dosing for the condition treated? Y N

    Please document the indication/condition treated and total dose (units) requested:

    _____

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature Date