



CIGNA

Pharmacy Services

Phone: (800)244-6224

Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form - Botox (botulinum toxin type A) -

Notice: Failure to complete this form in its entirety or include chart notes may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider 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 or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes <input type="checkbox"/> No <input type="checkbox"/>			* Patient Street Address:		
* May we fax our response to your office? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		
Medication requested:					
<input type="checkbox"/> Botox 100 unit vial					
Dose and Quantity:		Duration of therapy:		J-Code:	CPT Code:
In what location(s) of the body will Botox injections be given (please specify how many units are being injected into each muscle and how often they will be given)?					
Where will this medication be obtained?					
<input type="checkbox"/> CIGNA Tel-Drug (CIGNA's nationally preferred 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):					
Please indicate the condition Botox is being used to treat and answer additional questions as necessary. Please include all applicable chart notes with this form.					
<input type="checkbox"/>	Blepharospasm				
<input type="checkbox"/>	Cervical dystonia, including spasmodic torticollis				
<input type="checkbox"/>	Additional Question(s)	Is the patient's condition causing persistent pain or interfering with the patient's ability to perform age-related activities of daily living?		Answer/Detail:	
<input type="checkbox"/>	Focal hand dystonia (e.g., writer's cramp)				
<input type="checkbox"/>	Additional Question(s)	Is the patient's condition causing persistent pain or interfering with the patient's ability to perform age-related activities of daily living?		Answer/Detail:	
<input type="checkbox"/>	Adductor spasmodic dysphonia/laryngeal dystonia				
<input type="checkbox"/>	Jaw-closing oromandibular dystonia				
<input type="checkbox"/>	Additional Question(s)	Is the patient's condition causing persistent pain, interference with nutritional intake (e.g., masticatory dysfunction that results in weight loss or malnutrition), or significant speech impairment/interference with the ability to communicate effectively?		Answer/Detail:	
<input type="checkbox"/>	Meige's syndrome/cranial dystonia (i.e., blepharospasm with jaw-closing oromandibular cervical dystonia)				

	Additional Question(s)	Is the patient's condition causing persistent pain, interference with nutritional intake (e.g., masticatory dysfunction that results in weight loss or malnutrition), or significant speech impairment/interference with the ability to communicate effectively?	Answer/Detail:
<input type="checkbox"/>	Spasticity due to cerebral palsy (including spastic equinus foot deformities)		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Spasticity due to cerebrovascular accident		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Spasticity due to localized adductor muscle spasticity in multiple sclerosis		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Spasticity due to spinal cord injury		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Spasticity due to traumatic brain injury		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Spasticity due to hereditary spastic paraplegia		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Hemifacial spasms/Seventh cranial nerve palsy		
	Additional Question(s)	Is the patient's condition causing persistent pain or vision impairment?	Answer/Detail:
<input type="checkbox"/>	Horizontal strabismus in an adult		
	Additional Question(s)	How many prism diopters does the patient have?	Answer/Detail:
		Does the patient have diplopia, impaired depth perception, impaired peripheral vision, or impaired ability to maintain fusion?	Answer/Detail:
<input type="checkbox"/>	Vertical strabismus in an adult		
	Additional Question(s)	Does the patient have diplopia, impaired depth perception, impaired peripheral vision, or impaired ability to maintain fusion?	Answer/Detail:
<input type="checkbox"/>	Persistent sixth nerve palsy in an adult		
	Additional Question(s)	When was the patient diagnosed with this condition?	Answer/Detail:
		Does the patient have diplopia, impaired depth perception, impaired peripheral vision, or impaired ability to maintain fusion?	Answer/Detail:
<input type="checkbox"/>	Strabismus disorder in a child		
	Additional Question(s)	Is Botox being used to achieve normal binocular motor alignment?	Answer/Detail:
<input type="checkbox"/>	Primary esophageal achalasia		
	Additional Question(s)	Is the patient considered a poor surgical risk (e.g., patients with comorbidities such as elderly patients with decreased life expectancy)?	Answer/Detail:

		Does the patient have a history of perforation caused by previous pneumatic dilatation?	Answer/Detail:
<input type="checkbox"/>	Chronic anal fissure		
<input type="checkbox"/>	Additional Question(s)	Has the patient failed conventional non-surgical treatment (e.g., nitrate preparations, sitz baths, stool softeners, bulk agents, diet modifications)	Answer/Detail:
<input type="checkbox"/>	Primary or secondary axillary or palmar hyperhidrosis OR gustatory sweating (Frey's syndrome)		
<input type="checkbox"/>	Additional Question(s)	Has patient had prior trial of topical therapy? If yes please list agent, duration and outcome.	Answer/Detail:
<input type="checkbox"/>		Has patient had prior trial of oral pharmacotherapy? If yes please list drug, duration and outcome.	Answer/Detail:
<input type="checkbox"/>		Is the condition significantly interfering with the patient's ability to perform age-appropriate activities of daily living?	Answer/Detail:
<input type="checkbox"/>		The condition is causing persistent or chronic cutaneous conditions such as skin maceration, dermatitis, fungal infections and secondary microbial conditions?	Answer/Detail:
<input type="checkbox"/>	Disabling essential tremor, including head and neck, hand, and voice tremor		
<input type="checkbox"/>	Excessive glandular secretion		
<input type="checkbox"/>	Additional Question(s)	Does the patient have cholinergic-mediated secretions associated with various types of fistulas (e.g., parotid gland, pharyngocutaneous)?	Answer/Detail:
<input type="checkbox"/>		Does the patient have ptialism/sialorrhea (excessive salivation) associated with parkinsonism and cerebral palsy, refractory to pharmacotherapy (including anticholinergics)?	Answer/Detail:
<input type="checkbox"/>	Voiding dysfunction associated with intracranial lesions or cerebrovascular accident-induced voiding difficulty		
<input type="checkbox"/>	Voiding dysfunction associated with detrusor sphincter dyssynergia due to spinal cord injury		
<input type="checkbox"/>	Migraine Prophylaxis		
<input type="checkbox"/>	Additional Question(s)	Did the patient have a failure, contraindication, or intolerance to two migraine prophylaxis medications: beta-blockers, calcium channel blockers, tricyclic antidepressants or anticonvulsant medications?	Answer/Detail:
<input type="checkbox"/>	Other (Please specify diagnosis and any additional applicable information):		

CIGNA HealthCare's coverage position on this and other medications may be viewed online at: http://www.cigna.com/customer_care/healthcare_professional/coverage_positions

Please fax completed form to (800)390-9745. Due to the clinical information required, requests for Botox cannot be accepted via phone.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to have the request expedited. View our formulary on line at <http://www.cigna.com>.

"CIGNA Pharmacy Management" or "CIGNA HealthCare" refer to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C., and HMO or service company subsidiaries of CIGNA Health Corporation.

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