Myobloc® (rimabotulinumtoxinB) Injectable Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 **(TTY:**711**)**
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	Email:	
Patient Current Weight: ____ lbs or ____ kgs Patient Height: ____ inches or ____ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #:

Medicaid: ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

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:	

Specialty *(Check one)*: ☐ Dermatologist ☐ Neurologist ☐ Orthopedist ☐ Otolaryngologist ☐ Physiatrist ☐ Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: **Myobloc (rimabotulinumtoxinB) Dose:** _____ **Frequency:** _____

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

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.

For All Requests (clinical documentation required):

☐ Yes ☐ No Is therapy prescribed for cosmetic purposes (e.g., treatment of wrinkles or uncorrected congenital strabismus and no binocular fusion)?

For Initiation Requests (clinical documentation required):

☐ **Cervical dystonia (e.g., torticollis)**
- ☐ Yes ☐ No Prior to initiating therapy with the requested drug, was/is there abnormal placement of the head with limited range of motion in the neck?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?

☐ **Chronic sialorrhea (excessive salivation)**
- ☐ Yes ☐ No Is the patient refractory to pharmacotherapy (e.g., anticholinergics)?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist or otolaryngologist?

☐ **Primary axillary or palmar hyperhidrosis**
- ☐ Yes ☐ No Has significant disruption of professional and/or social life occurred because of excessive sweating?
- ☐ Yes ☐ No Has the patient tried topical aluminum chloride or other extra-strength antiperspirants?
  - → ☐ Yes ☐ No Was the topical aluminum chloride or other extra-strength antiperspirant ineffective or resulted in a severe rash?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, internist, or dermatologist?

☐ **Upper limb spasticity**
- ☐ Yes ☐ No Is the spasticity either the primary diagnosis or a symptom of a condition causing limb spasticity?
- ☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist, orthopedist, or physiatrist?

Continued on next page

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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.

Please indicate the preferred alternatives that have been ineffective, not tolerated, or are contraindicated:

☐ Botox ☐ Dysport ☐ Xeomin

For Continuation Requests (clinical documentation required):

☐ Yes ☐ No Was the requested drug effective for treating the diagnosis or condition?

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.