# Xeomin® (incobotulinumtoxinA) 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):* ☐ Neurologist ☐ Ophthalmologist ☐ 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**: **Xeomin (incobotulinumtoxinA) 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):**

☐ **Blepharospasm, including blepharospasm associated with dystonia and benign essential blepharospasm**
☐ Yes ☐ No Will the requested drug be prescribed by or in consultation with a neurologist or ophthalmologist?

☐ **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?

☐ **Upper limb spasticity**
☐ Yes ☐ No Is the spasticity either the primary diagnosis or as 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?

***For patients less than 18 years of age:***
☐ Yes ☐ No Is the patient a pediatric patient between the age of 2 and 17 and the spasticity is not caused by cerebral palsy?

**For Continuation Requests (clinical documentation required):**

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

***Continued on next page***

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

## 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.