

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Botox (IL88)

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 Medicaid at 1-855-684-5250.

Please contact Aetna Better Health Illinois Medicaid at 1-866-212-2851 with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Botox (IL88).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Botox (onabotulinumtoxinA)

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: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Is Botox being prescribed for cosmetic purposes? Y N

[If yes, no further questions.]

2. Is Botox prescribed by a specialist based on the condition treated? (e.g., neurologist, headache specialist, physical medicine, ophthalmologist, dermatologist) Y N
Please document specialty: _____

[If no, no further questions.]

3. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file) Y N

under Aetna Better Health)?

[If yes, skip to question 25.]

- | | | |
|---|---|---|
| 4. Is Botox being prescribed for ANY of the following conditions? Cervical dystonia \ Blepharospasm \ Strabismus Please document diagnosis: | Y | N |
|---|---|---|
-

[If no, skip to question 6.]

- | | | |
|---|---|---|
| 5. Is the patient at least 16 years of age? | Y | N |
|---|---|---|

[If no, no further questions]

[If yes, skip to question 27.]

- | | | |
|---|---|---|
| 6. Does the patient have a diagnosis of hemifacial spasm? | Y | N |
|---|---|---|

[If yes, skip to question 9.]

- | | | |
|---|---|---|
| 7. Does the patient have a diagnosis of upper or lower limb spasticity? | Y | N |
|---|---|---|

[If no, skip to question 10.]

- | | | |
|--|---|---|
| 8. Is the patient at least 18 years old? | Y | N |
|--|---|---|

[If no, no further questions.]

- | | | |
|--|---|---|
| 9. Has the patient had a trial and failure of at least 2 formulary muscle relaxants, including baclofen and tizanidine? Please document drugs tried: | Y | N |
|--|---|---|
-

[If no, no further questions.]

[If yes, skip to question 27.]

- | | | |
|---|---|---|
| 10. Does the patient have a diagnosis of severe primary axillary hyperhidrosis? | Y | N |
|---|---|---|

[If no, skip to question 14.]

- | | | |
|---|---|---|
| 11. Is the patient at least 18 years old? | Y | N |
|---|---|---|

[If no, no further questions.]

- | | | |
|---|---|---|
| 12. Does the patient have medical complications such as skin maceration with secondary skin infections? | Y | N |
|---|---|---|

[If no, no further questions.]

- | | | |
|---|---|---|
| 13. Has the patient had a trial and failure of a 2 month trial of | Y | N |
|---|---|---|

topical aluminum chloride 20%?

[If no, no further questions.]

[If yes, skip to question 27.]

14. Is Botox being prescribed for migraine prophylaxis? Y N

[If no, skip to question 18.]

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

[If no, no further questions.]

16. Does the patient have a documented frequency of more than 15 migraine headaches in a 30-day period, with each headache lasting 4 hours or longer? Y N

[If no, no further questions]

17. Has the patient had a documented failure or intolerance to 2 different classes of prophylactic medications used for migraine prophylaxis: beta blocker (propranolol, metoprolol, timolol, atenolol, nadolol), anticonvulsant (divalproex, valproate, topiramate), antidepressants (amitriptyline, venlafaxine)? Please document medications tried: Y N

[If no, no further questions]

[If yes, skip to question 27.]

18. Is Botox being prescribed for treatment of neurogenic bladder? Y N

[If no, skip to question 21.]

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

[If no, no further questions.]

20. Has the patient had a trial and failure of 2 first-line agents, such as oxybutynin and trospium (Sanctura)? Please document medications tried: Y N

[If no, no further questions.]

[If yes, skip to question 27.]

21. Is Botox being prescribed for any of the following conditions? Y N

Chronic management of focal spasticity in pediatric patient (2-18 years of age) with cerebral palsy with concurrent equinus gait (tiptoeing) \ Classical achalasia

[If yes, skip to question 27.]

22. Does the patient have a diagnosis of sialorrhea (excessive drooling) associated with neurological disorders (i.e., Parkinson's disease, amyotrophic lateral sclerosis, cerebral palsy)? Y N

[If no, no further questions.]

23. Is the patient at least 4 years old? Y N

[If no, no further questions.]

24. Has the patient had a trial and failure of glycopyrrolate and benztropine? Please document medications tried: Y N

[If yes, skip to question 27.]

[If no, no further questions.]

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

[If no, no further questions.]

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

[If no, no further questions.]

27. Is the dose prescribed within the FDA-approved dosing for the condition treated? Please document the indication/condition treated and total dose (units) requested: Y N

Comments:

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

Prescriber (Or Authorized) Signature

Date

