04/18/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Dysport, Myobloc, Xeomin (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 Dysport, Myobloc, Xeomin (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)

Dysport (abobotulinumtoxinA) Myobloc (rimabotulinumtoxinB) Xeomin (incobotulinumtoxinA)

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 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). Please indicate specialty: Y N

   _____

   [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 under Aetna Better Health)? Y N

   *Note: A documented response to treatment will be required for reauthorization.

   [If yes, skip to question 19.]

4. Does the patient have a diagnosis of cervical dystonia? Y N

   [If no, skip to question 6.]

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

   [If yes, skip to question 21.]

   [If no, no further questions.]

6. Is the request for Myobloc? Y N

   [If no, skip to question 10.]

7. 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.]

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

   [If no, no further questions.]

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

   _____

   [If yes, skip to question 21.]

   [If no, no further questions]

10. Does the patient have a diagnosis of blepharospasm? Y N

    [If no, skip to question 12.]

11. Is the patient at least 16 years of age? Y N

    [If yes, skip to question 21.]

    [If no, no further questions.]

12. Is the request for Dysport? Y N

    [If no, no further questions.]

13. Does the patient have a diagnosis of severe primary axillary hyperhidrosis? Y N

    [If no, skip to question 17.]

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

    [If no, no further questions.]

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

    [If no, no further questions.]

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

    [If no, no further questions]

    [If yes, skip to question 21.]

17. Does the patient have a diagnosis of hemifacial spasm? Y N

    [If no, no further questions.]

18. 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 21.]

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

    [If no, no further questions.]

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

    [If no, no further questions.]

21. 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