

**CIGNA Specialty Pharmacy Services**  
**Botulinum Toxin Fax Order Form**



Please deliver by: \_\_\_\_\_

Requests received after 4 p.m. CT will begin processing the following business day

Fax: 1.800.351.3616  
 Phone: 1.800.351.3606

Order #: \_\_\_\_\_ Referral Source Code: 652

| PATIENT INFORMATION (Please Print)   |            | PHYSICIAN INFORMATION   |                  |
|--|------------|---|------------------|
| PATIENT NAME:  |            | DATE OF BIRTH :   | NAME:            |
| HEALTH CARE ID #:  |            | SEX:<br><input type="checkbox"/> M <input type="checkbox"/> F   | DEA #:           |
| NPI:   |            |   |                  |
| HOME PHONE:  | ALT PHONE: | TELEPHONE:  | FAX:             |
| ADDRESS: (Street) (City) (State) (Zip Code)  |            | SHIPPING ADDRESS: (Street/Suite #) (City) (State) (Zip Code)  |                  |
| ALLERGIES:<br>If no allergies are specified, for new customers this indicates no known allergies and for existing customers this indicates no change from information provided to CIGNA Specialty Pharmacy previously. |            | SHIP MEDICATIONS TO:<br><input checked="" type="checkbox"/> <b>Physician's Office</b><br>Please note we are unable to ship Botox/ Dysport/ Myobloc directly to the patient. Please provide a physician's office shipping address in the space provided above. |                  |
| *Is your fax machine kept in a secure location? <input type="checkbox"/> Yes <input type="checkbox"/> No   |            | *May we fax our response to your office? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                  |
| PRESCRIPTION INFORMATION   |            |   |                  |
| <b>BOTOX®</b> (OnabotulinumtoxinA - J0585)<br><input type="checkbox"/> 100 Unit Vial<br><input type="checkbox"/> 200 Unit Vial   |            | DIRECTIONS:   | NUMBER OF VIALS: |
|  |            |   | REFILLS:         |
| <b>DYSPORT®</b> (AbobotulinumtoxinA – J0586)<br><input type="checkbox"/> 300 Unit Vial<br><input type="checkbox"/> 500 Unit Vial   |            | DIRECTIONS:   | NUMBER OF VIALS: |
|  |            |   | REFILLS:         |
| <b>MYOBLOC®</b> (RimabotulinumtoxinB – J0587)<br><input type="checkbox"/> 2,500 Unit/ 0.5ml Vial<br><input type="checkbox"/> 5,000 Unit/ 1 ml Vial<br><input type="checkbox"/> 10,000 Unit/ 2ml Vial                   |            | DIRECTIONS:   | NUMBER OF VIALS: |
|  |            |   | REFILLS:         |
| <b>XEOMIN®</b> (IncobotulinumtoxinA – J3590)<br><input type="checkbox"/> 50 Unit Vial<br><input type="checkbox"/> 100 Unit Vial  |            | DIRECTIONS:   | NUMBER OF VIALS: |
|  |            |   | REFILLS:         |
| PRESCRIBER'S PRINTED NAME:   |            | DATE:   |                  |
| PRESCRIBER'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)  |            |   |                  |
| In order for a brand name product to be dispensed, the prescriber must handwrite " <b>Brand Necessary</b> " or " <b>Brand Medically Necessary</b> " on the prescription  |            |   |                  |
| <b>PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:</b>  |            |   |                  |
| Diagnosis Code (ICD-9): _____  |            |   |                  |
| In what location(s) of the body will injections be given (please specify how many units are being injected into each muscle)?  |            |   |                  |

Please indicate the condition Botox/ Dysport/ Myobloc is being used to treat and answer additional questions as necessary. Please include all applicable chart notes with this form.

|                          |   |  |                |
|--------------------------|---|--|----------------|
| <input type="checkbox"/> | <b>Blepharospasm</b>  |  |                |
| <input type="checkbox"/> | <b>Cervical dystonia, including spasmodic torticollis</b>   |  |                |
|                          | 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"/> | <b>Focal hand dystonia (e.g., writer's cramp)</b>   |  |                |
|                          | 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"/> | <b>Adductor spasmodic dysphonia/laryngeal dystonia</b>  |  |                |
| <input type="checkbox"/> | <b>Jaw-closing oromandibular dystonia</b>   |  |                |
|                          | 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"/> | <b>Meige's syndrome/cranial dystonia (i.e., blepharospasm with jaw-closing oromandibular cervical dystonia)</b> |  |                |
|                          | 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"/> | <b>Spasticity due to cerebral palsy (including spastic equinus foot deformities)</b>                            |  |                |
|                          | Additional Question(s)  | What is the specific location of the spasticity?   | Answer/Detail: |
| <input type="checkbox"/> | <b>Spasticity due to cerebrovascular accident</b>   |  |                |
|                          | Additional Question(s)  | What is the specific location of the spasticity?   | Answer/Detail: |
| <input type="checkbox"/> | <b>Spasticity due to localized adductor muscle spasticity in multiple sclerosis</b>                             |  |                |
|                          | Additional Question(s)  | What is the specific location of the spasticity?   | Answer/Detail: |
| <input type="checkbox"/> | <b>Spasticity due to spinal cord injury</b>   |  |                |
|                          | Additional Question(s)  | What is the specific location of the spasticity?   | Answer/Detail: |
| <input type="checkbox"/> | <b>Spasticity due to traumatic brain injury</b>   |  |                |
|                          | Additional Question(s)  | What is the specific location of the spasticity?   | Answer/Detail: |
| <input type="checkbox"/> | <b>Spasticity due to hereditary spastic paraplegia</b>  |  |                |
|                          | Additional Question(s)  | What is the specific location of the spasticity?   | Answer/Detail: |
| <input type="checkbox"/> | <b>Hemifacial spasms/Seventh cranial nerve palsy</b>  |  |                |
|                          | Additional Question(s)  | Is the patient's condition causing persistent pain or vision impairment?   | Answer/Detail: |

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|  |  |  |                |
|--|--|--|----------------|
| <b>Horizontal strabismus in an adult</b>   |  |  |                |
| <input type="checkbox"/>   | 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: |
| <b>Vertical strabismus in an adult</b>   |  |  |                |
| <input type="checkbox"/>   | Additional Question(s)   | Does the patient have diplopia, impaired depth perception, impaired peripheral vision, or impaired ability to maintain fusion?   | Answer/Detail: |
| <b>Persistent sixth nerve palsy in an adult</b>  |  |  |                |
| <input type="checkbox"/>   | 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: |
| <b>Strabismus disorder in a child</b>  |  |  |                |
| <input type="checkbox"/>   | Additional Question(s)   | Is Botox being used to achieve normal binocular motor alignment?   | Answer/Detail: |
| <b>Primary esophageal achalasia</b>  |  |  |                |
| <input type="checkbox"/>   | 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: |
| <b>Chronic anal fissure</b>  |  |  |                |
| <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: |
| <b>Primary or secondary axillary or palmar hyperhidrosis OR gustatory sweating (Frey's syndrome)</b> |  |  |                |
| <input type="checkbox"/>   | Additional Question(s)   | Has patient had prior trial of topical therapy? If yes please list agent, duration and outcome.  | Answer/Detail: |
|  |  | Has patient had prior trial of oral pharmacotherapy? If yes please list drug, duration and outcome.  | Answer/Detail: |
|  |  | Is the condition significantly interfering with the patient's ability to perform age-appropriate activities of daily living?   | Answer/Detail: |
|  |  | 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"/>   | <b>Disabling essential tremor, including head and neck, hand, and voice tremor</b> |  |                |
| <b>Excessive glandular secretion</b>   |  |  |                |
| <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: |
|  |  | Does the patient have ptyalism/sialorrhea (excessive salivation) associated with parkinsonism and cerebral palsy, refractory to pharmacotherapy ( including anticholinergics)? | Answer/Detail: |

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|                          |  |   |                |
|--------------------------|--|---|----------------|
| <input type="checkbox"/> | <b>Voiding dysfunction associated with intracranial lesions or cerebrovascular accident-induced voiding difficulty</b> |   |                |
| <input type="checkbox"/> | <b>Voiding dysfunction associated with detrusor sphincter dyssynergia due to spinal cord injury</b>                    |   |                |
| <input type="checkbox"/> | <b>Migraine prophylaxis</b>  |   |                |
|                          | 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"/> | <b>Other (Please specify diagnosis and any additional applicable information)</b>                                      |   |                |