

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: <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: <small>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.</small>		SHIP MEDICATIONS TO: <input checked="" type="checkbox"/> Physician's Office <small>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.</small>	
*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			
BOTOX® (OnabotulinumtoxinA - J0585) <input type="checkbox"/> 100 Unit Vial <input type="checkbox"/> 200 Unit Vial	DIRECTIONS:	NUMBER OF VIALS:	
		REFILLS:	
DYSPORT® (AbobotulinumtoxinA – J0586) <input type="checkbox"/> 300 Unit Vial <input type="checkbox"/> 500 Unit Vial	DIRECTIONS:	NUMBER OF VIALS:	
		REFILLS:	
MYOBLOC® (RimabotulinumtoxinB – J0587) <input type="checkbox"/> 2,500 Unit/ 0.5ml Vial <input type="checkbox"/> 5,000 Unit/ 1 ml Vial <input type="checkbox"/> 10,000 Unit/ 2ml Vial	DIRECTIONS:	NUMBER OF VIALS:	
		REFILLS:	
XEOMIN® (IncobotulinumtoxinA – J3590) <input type="checkbox"/> 50 Unit Vial <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 " Brand Necessary " or " Brand Medically Necessary " on the prescription			
PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:			
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"/>	Blepharospasm		
<input type="checkbox"/>	Cervical dystonia, including spasmodic torticollis		
	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"/>	Focal hand dystonia (e.g., writer's cramp)		
	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"/>	Adductor spasmodic dysphonia/laryngeal dystonia		
<input type="checkbox"/>	Jaw-closing oromandibular dystonia		
	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"/>	Meige's syndrome/cranial dystonia (i.e., blepharospasm with jaw-closing oromandibular cervical dystonia)		
	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"/>	Spasticity due to cerebral palsy (including spastic equinus foot deformities)		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Spasticity due to cerebrovascular accident		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Spasticity due to localized adductor muscle spasticity in multiple sclerosis		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Spasticity due to spinal cord injury		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Spasticity due to traumatic brain injury		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Spasticity due to hereditary spastic paraplegia		
	Additional Question(s)	What is the specific location of the spasticity?	Answer/Detail:
<input type="checkbox"/>	Hemifacial spasms/Seventh cranial nerve palsy		
	Additional Question(s)	Is the patient's condition causing persistent pain or vision impairment?	Answer/Detail:

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Horizontal strabismus in an adult			
<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:
Vertical strabismus in an adult			
<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:
Persistent sixth nerve palsy in an adult			
<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:
Strabismus disorder in a child			
<input type="checkbox"/>	Additional Question(s)	Is Botox being used to achieve normal binocular motor alignment?	Answer/Detail:
Primary esophageal achalasia			
<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:
Chronic anal fissure			
<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:
Primary or secondary axillary or palmar hyperhidrosis OR gustatory sweating (Frey's syndrome)			
<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"/>	Disabling essential tremor, including head and neck, hand, and voice tremor		
Excessive glandular secretion			
<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"/>	Voiding dysfunction associated with intracranial lesions or cerebrovascular accident-induced voiding difficulty		
<input type="checkbox"/>	Voiding dysfunction associated with detrusor sphincter dyssynergia due to spinal cord injury		
<input type="checkbox"/>	Migraine prophylaxis		
	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"/>	Other (Please specify diagnosis and any additional applicable information)		