Cigna®

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Dysport and Xeomin

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			**Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.**		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ☐ Dysport ☐ Xeomin

Total Dose Requested: Frequency of Administration: Quantity:

List all muscles/sites that the medication will be injected at and list number of units being injected:

1._____**units into** _____
2. _____**units into** _____
3. _____**units into** _____
4. _____**units into** _____
5._____**units into** _____
6._____**units into** _____
7._____**units into** _____
8._____**units into** _____
9._____**units into** _____
10._____**units into** _____

Duration of therapy: J-Code: CPT Code: ICD10:
Is this for new therapy or continued therapy? ☐ new therapy ☐ continued therapy
If *continued therapy*, what previous doses and frequency has your patient tried?

If requesting more than 1 treatment every 90 days:
Please provide clinical support for this dosing, including past treatment dates/doses with this drug, documentation of clinical improvement and duration of benefit.

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ blepharospasm
☐ cervical dystonia/spasmodic torticollis
☐ cerebral palsy (including spastic equinus foot deformities)
☐ Hirschsprung disease
☐ multiple sclerosis and localized adductor muscle spasticity
☐ chronic sialorrhea
☐ lower limb spasticity
☐ upper limb spasticity
☐ other (please specify):

Where will this medication be obtained?

☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
**Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

If blepharospam:

Does your patient have intermittent or sustained closure of the eyelids caused by involuntary contractions of the orbicularis oculi muscle? Yes ☐ No ☐
Was this drug prescribed by, or in consultation with, a neurologist or ophthalmologist? Yes ☐ No ☐

If cervical dystonia/spasmodic torticollis

Does your patient have involuntary, simultaneous activation of agonist and antagonist muscles of the neck and shoulder (for example, sternocleidomastoid, splenius, levator scapulae, trapezius, semispinalis, scalene)? Yes ☐ No ☐
Does your patient have sustained head torsion and/or tilt with limited range of motion in the neck? Yes ☐ No ☐
Was this drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist or a physical medicine and rehabilitation physician? Yes ☐ No ☐

If Hirschsprung disease

Is this medication being used to treat obstructive symptoms due to a non-relaxing internal anal sphincter following surgery? Yes ☐ No ☐
Was this drug prescribed by, or in consultation with, a gastroenterologist? Yes ☐ No ☐

If chronic sialorrhea

Was this drug prescribed by, or in consultation with, a neurologist or an otolaryngologist? Yes ☐ No ☐

If lower limb spasticity

Is there documentation that your patient has had a significant decrease of function or Activities of Daily Living (for example, walking)? Yes ☐ No ☐
Was this drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist or a physical medicine and rehabilitation physician? Yes ☐ No ☐

If upper limb spasticity

Is there documentation that your patient has had a significant decrease of function or Activities of Daily Living (for example, eating, washing)? Yes ☐ No ☐
Was this drug prescribed by, or in consultation with, a board certified pain management specialist, a neurologist or a physical medicine and rehabilitation physician? Yes ☐ No ☐

Additional Pertinent Information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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