Clinical Criteria Worksheet: AbobotulinumtoxinA (Dysport®)

Claim Submission

- Claim processing may be delayed if the information submitted in this worksheet is illegible.
- If the worksheet is left blank or information is missing the claim will be rejected for not enough documentation and reimbursement will be delayed.
- A claim should not be submitted until the drug has been administered to the patient.
- The manufacturer invoice showing the acquisition cost of the drug administered, including all discounts, rebates, and incentives must be submitted with the claim. The invoice must be dated within 6 months prior to the date of service and/or should include the expiration date of the drug, or it will be rejected for not enough documentation.

Enrollee Information

Enrollee Last Name:	Enrollee First Name:											
Date of Birth (MM/DD/YYYY):	Enrollee Medicaid JD (2 letters, 5 numbers, 1 letter):											
Address:												
City, Town or Post Office:	State: ZIP Code:											
	$\mathbf{\nabla}$											
Prescriber Information												
Prescriber Last Name:	Prescriber First Name:											
National Provider Identifier (NPI) Number:												
Preferred Contact (Telephone Number)												

Enrollee Last Name:	Enrollee First Name:												
Clinical Criteria – Drug Information													
Drug Administration:													
Provide the date of drug administration (MM/DD/YYYY	(): ••••••••••••••••••••••••••••••••••••												
Drug name and strength:	<u>i</u>												
AbobotulinumtoxinA (Dysport®) 300 units vial													
AbobotulinumtoxinA (Dysport [®]) 500 units vial													
Patient's current weight:kg Administration dose (units) and frequency:													
Quantity of vials needed:													
New treatment: 🗌 Yes 🗌 No													
If No , date therapy initiated (MM/DD/YYYY):													

Enrollee Last Name:							Enrollee First Name:																

Clinical Criteria – Diagnosis

1. Diagnosis related to use:	
Food and Drug Administration Indications:	Compendia Supported Uses:
Cervical dystonia	🗌 Blepharospasm
Spasticity	Hemifacial spasm
Other:	
Clinical Criteria	
2. Please indicate if this request is for the init	iation or continuation of AbobotulinumtoxinA therapy:
Initiation Continuation	
C N	
Attestation	

I attest that this drug is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.