

Enrollee Last Name:

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Enrollee First Name:

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Clinical Criteria – Drug Information

Drug Administration:

Provide the date of drug administration (MM/DD/YYYY):

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Drug name and strength:

- 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):

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Archived December 2024

Enrollee Last Name:

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Enrollee First Name:

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Clinical Criteria – Diagnosis

1. Diagnosis related to use:

Food and Drug Administration Indications: <input type="checkbox"/> Cervical dystonia <input type="checkbox"/> Spasticity	Compendia Supported Uses: <input type="checkbox"/> Blepharospasm <input type="checkbox"/> Hemifacial spasm
<input type="checkbox"/> Other: _____	

Clinical Criteria

2. Please indicate if this request is for the initiation or continuation of AbobotulinumtoxinA therapy:

- Initiation
 Continuation

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.

Prescriber Signature (Required)

Date (MM/DD/YYYY)

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