Clinical Criteria Worksheet: OnabotulinumtoxinA (Botox®)

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 ID (2 letters, 5 numbers, 1 letter):

Address:

City, Town or Post Office:

State:

ZIP Code:

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:

☐ OnabotulinumtoxinA (Botox®) 100 units vial

☐ OnabotulinumtoxinA (Botox®) 200 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**:
☐ Axillary hyperhidrosis (severe) ☐ Blepharospasm associated with dystonia ☐ Cervical dystonia ☐ Chronic migraine prophylaxis ☐ Neurogenic detrusor overactivity ☐ Overactive bladder ☐ Spasticity ☐ Strabismus ☐ Urinary incontinence due to detrusor overactivity	☐ Achalasia ☐ Auricolotemporal syndrome ☐ Backache ☐ Benign prostatic hyperplasia ☐ Cervicogenic headache ☐ Difficulty talking – total laryngectomy ☐ Disorder of esophagus ☐ Disorder of nervous system – excessive salivation ☐ Epicondylitis ☐ Excessive salivation – Advanced Parkinson's disease ☐ Fibromyalgia ☐ Gilles de la Tourette's syndrome ☐ Granuloma of vocal cords – refractory to conventional surgical/medical therapies ☐ Hemifacial spasm ☐ Idiopathic trigeminal neuralgia – refractory ☐ Injury to oculomotor nerve (acute) ☐ Isolated oromandibular dystonia ☐ Larynx closure – adjunct to surgical procedure ☐ Organic voice tremor ☐ Pelvic floor dyssynergia ☐ Spasm of pharyngoesophageal segment – total laryngectomy ☐ Spastic dysphonia ☐ Stuttering ☐ Tardive dyskinesia ☐ Temporomandibular joint disorder ☐ Whiplash injury to neck
☐ Other: _____	

Enrollee Last Name:

Enrollee First Name:

Clinical Criteria

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

   ☐ Initiation ☐ Continuation

3. If for chronic migraine prophylaxis, does the patient have headaches greater than or equal to 15 days per month, with headache lasting greater than or equal to 4 hours per day?

   ☐ Yes ☐ No ☐ Not Applicable

   If YES, has the patient tried two FDA approved or Compendia supported oral preventive agents (amitriptyline, beta-blockers [atenolol, metoprolol, nadolol, propranolol, timolol], divalproex sodium/valproate sodium/valproic acid, topiramate, or venlafaxine)?

   ☐ Yes ☐ No ☐ Not Applicable

   Please provide the names of the most recent therapies and dates of the trials. Please write N/A if this question is not applicable based on diagnosis.

   Drug name and strength:_____ Date(s) of use:_____

   Drug name and strength:_____ Date(s) of use:_____

4. If for overactive bladder or urinary incontinence due to detrusor overactivity, has the patient tried an antimuscarinic agent or beta-3 adrenergic agonist?

   ☐ Yes ☐ No ☐ Not Applicable

   Please provide the name of the most recent therapy and dates of the trial. Please write N/A if this question is not applicable based on diagnosis.

   Drug name and strength:_____ Date(s) of use:_____

5. If for neurogenic detrusor overactivity, does the patient have a diagnosis of multiple sclerosis or spinal cord injury?

   ☐ Yes ☐ No ☐ Not Applicable

   If NO, has the patient tried an antimuscarinic agent?

   ☐ Yes ☐ No ☐ Not Applicable

   Please provide the name of the most recent therapy and dates of the trial. Please write N/A if this question is not applicable based on diagnosis.

   Drug name and strength:_____ Date(s) of use:_____

Enrollee Last Name:

Enrollee First Name:

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)