Clinical Criteria Worksheet:
AbobotulinumtoxinA (Dysport®)

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): _____

Clinical Criteria – Drug Information

Drug Administration:

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

☐☐ / ☐☐ / ☐☐☐☐

Drug name and strength:

☐ AbobotulinumtoxinA (Dysport®) 300 units vial

☐ AbobotulinumtoxinA (Dysport®) 500 units vial

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 ☐ Spasticity	☐ Blepharospasm ☐ Hemifacial spasm
☐ 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)**