

**Clinical Criteria Worksheet:  
DaxibotulinumtoxinA-ianm (Daxxify®)**

**Enrollee Information**

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Enrollee Last Name:

Enrollee First Name:

Date of Birth (MM/DD/YYYY):

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

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Address:

City, Town or Post Office:

State:

ZIP Code:

**Prescriber Information**

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Prescriber Last Name:

Prescriber First Name:

National Provider Identifier (NPI) Number: \_\_\_\_\_

Preferred Contact (Telephone Number): \_\_\_\_\_

**Clinical Criteria – Drug Information**

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**Drug Administration:**

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

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**Drug name and strength:**

daxibotulinumtoxinA- ianm (Daxxify®) 100 units vial

**New treatment:**     Yes     No

If **No**, date therapy initiated (MM/DD/YYYY):

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Enrollee Last Name:

Enrollee First Name:

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## Clinical Criteria – Diagnosis

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1. Food and Drug Administration Indications:

Cervical dystonia

## Clinical Criteria

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

Initiation     Continuation

## Attestation

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*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.*

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Prescriber Signature (Required)

Date (MM/DD/YYYY)