Clinical Criteria Worksheet:
IncobotulinumtoxinA (Xeomin®)

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:

- ☐ IncobotulinumtoxinA (Xeomin®) 50 units vial
- ☐ IncobotulinumtoxinA (Xeomin®) 100 units vial
- ☐ IncobotulinumtoxinA (Xeomin®) 200 units vial

New treatment: ☐ Yes ☐ No

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

☐☐ / ☐☐ / ☐☐☐☐

Enrollee Last Name: ______________________________

Enrollee First Name: ______________________________

Clinical Criteria – Diagnosis

1. Food and Drug Administration Indications:

- ☐ Blepharospasm
- ☐ Cervical dystonia
- ☐ Chronic sialorrhea
- ☐ Upper limb spasticity
- ☐ Other: ____________________________

Clinical Criteria

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

   ☐ Initiation ☐ Continuation

3. If for chronic sialorrhea, has the patient had a trial with glycopyrrolate?

   ☐ Yes ☐ No ☐ Not Applicable

   If NO, does the patient have a diagnosis of Parkinson's disease or other neurodegenerative disesase?

   ☐ Yes ☐ No ☐ Not Applicable

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)**