Clinical Criteria Worksheet:
OnabotulinumtoxinA (Botox®)

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:

☐ OnabotulinumtoxinA (Botox®) 100 units vial

☐ OnabotulinumtoxinA (Botox®) 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. Diagnosis related to use:

Food and Drug Administration Indications:	**Compendia supported uses:**
☐ Primarly axillary hyperhidrosis (severe) ☐ Blepharospasm associated with dystonia ☐ Cervical dystonia ☐ Chronic migraine prophylaxis ☐ Neurogenic detrusor overactivity ☐ Overactive bladder ☐ Spasticity ☐ Strabismus	☐ Achalasia ☐ Auricolotemporal syndrome ☐ Backache ☐ Benign prostatic hyperplasia ☐ Cervicogenic headache ☐ Difficulty talking – total laryngectomy ☐ Dysphagia ☐ 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: _____	

Clinical Criteria

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

☐ Initiation ☐ Continuation

Enrollee Last Name: **Enrollee First Name:**

_____ _____

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:_____

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)**