Clinical Criteria Worksheet: AbobotulinumtoxinA (Dysport®)

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:

☐ AbobotulinumtoxinA (Dysport®) 300 units vial

☐ AbobotulinumtoxinA (Dysport®) 500 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:**
☐ 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)**