Clinical Criteria Worksheet: IncobotulinumtoxinA (Xeomin®)

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:

☐ IncobotulinumtoxinA (Xeomin®) 50 units vial

☐ IncobotulinumtoxinA (Xeomin®) 100 units vial

☐ IncobotulinumtoxinA (Xeomin®) 200 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):

		/			/				

Clinical Criteria – Diagnosis

1. Food and Drug Administration Indications:

☐ Blepharospasm
☐ Cervical dystonia
☐ Chronic sialorrhea
☐ Upper limb spasticity
☐ Other: _____

Enrollee Last Name:

Enrollee First Name:

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)**