

ALASKA MEDICAID

BOTOX® (Botulinum Toxin Type A)

Single use vials containing 100 Units of vacuum-dried *Clostridium botulinum* type A neurotoxin complex

PREFERRED DRUG:

NA

NON-PREFERRED DRUG:

NA

INDICATION:¹

BOTOX® is indicated for the treatment of:

1. Cervical dystonia.
2. Severe primary axillary hyperhidrosis that is inadequately managed with topical agents.
3. Strabismus and blepharospasm associated with dystonia.

CRITERIA FOR APPROVAL:

BOTOX® coverage will be given if it is being used to treat any of the following conditions:

1. Cervical dystonia.
2. Cerebral palsy spasticity.
3. Strabismus.
4. Severe, primary axillary, hyperhidrosis.
5. Migraine.
6. Parkinson's disease spasticity.
7. Idiopathic dystonias.
8. Spastic disorders associated with stroke.
9. Other spasticity related disorders.

LENGTH OF AUTHORIZATION:

1. Coverage may be approved for up to 6 months.

REQUESTS FOR RENEWAL OF COVERAGE:

1. Coverage may not be extended. After 6 months, a new prior authorization is required.

DISPENSING LIMIT:

1. The dispensing limit is a 30 day supply of medication.

REFERENCES / FOOTNOTES:

¹ Please refer to BOTOX[®] package insert, available at:
<<http://www.allergan.com/download/BotoxPI.pdf>> Accessed 06/21/07.