



Coverage Policy/Guideline

Name: Dysport	Page: 1 of 3
Effective Date: 12/17/2025	Last Review Date: 11/19/2025
Applies to: <input checked="" type="checkbox"/> Arizona	

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Dysport under the patient's prescription drug benefit.

Description:

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

A. FDA-Approved Indications

1. Treatment of cervical dystonia in adults
2. Treatment of spasticity in patients 2 years of age and older

B. Compendial Uses

1. Blepharospasm
2. Hemifacial spasm
3. Chronic anal fissures
4. Excessive salivation
5. Primary axillary hyperhidrosis

All other indications are considered experimental/investigational and not medically necessary.

Applicable Drug List:

Dysport

Policy/Guideline:

Prescriber Specialty:

The medication must be prescribed by or in consultation with a provider specialized in the treating the member's condition.

Exclusions:

Coverage will not be provided for cosmetic use.

Criteria for Initial Approval:

A. Cervical dystonia

Authorization of 12 months may be granted for treatment of adults with cervical dystonia (e.g., torticollis) when all of the following are met:

1. Member is 18 years of age or older



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2. Member has abnormal placement of the head with limited range of motion in the neck.

B. Upper or lower limb spasticity

Authorization of 12 months may be granted for treatment of upper or lower limb spasticity when ALL of the following are met:

1. Member is 2 years of age or older
2. Member has a primary diagnosis of upper or lower limb spasticity or as a symptom of a condition (including focal spasticity or equinus gait due to cerebral palsy)

C. Blepharospasm

Authorization of 12 months may be granted for treatment of blepharospasm, including blepharospasm associated with dystonia and benign essential blepharospasm.

D. Hemifacial spasm

Authorization of 12 months may be granted for treatment of hemifacial spasm.

E. Chronic anal fissures

Authorization of 12 months may be granted for treatment of chronic anal fissures when the member has not responded to first-line therapy such as topical calcium channel blockers or topical nitrates.

F. Excessive salivation

Authorization of 12 months may be granted for treatment of excessive salivation (chronic sialorrhea) when the member has been refractory to pharmacotherapy (e.g., anticholinergics).

G. Primary axillary hyperhidrosis

Authorization of 12 months may be granted for treatment of primary axillary hyperhidrosis when ALL of the following criteria are met:

1. Significant disruption of professional and/or social life has occurred because of excessive sweating; and
2. Topical aluminum chloride or other extra-strength antiperspirants are ineffective or result in a severe rash.

Continuation of Therapy:

All members (including new members) requesting authorization for continuation of therapy must meet all initial authorization criteria and be experiencing benefit from therapy.

Approval Duration and Quantity Restrictions:

Approval: 12 months



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References:

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