

Special Authorization Request Form, for:

BOTOX (*onabotulinumtoxin A*)

The purpose of this form is to obtain medical information required to assess your request for a drug on the Special Authorization (SA) list of the Reformulary. Please ensure that all information, including contact information, is complete. Completing this form is not a guarantee of approval.

PART 1: COMPLETE THIS INFORMATION

Information about plan member

First name: _____ Last name: _____

Group number: _____ Certificate number: _____

Date of birth (DD/MM/YY): _____ Gender: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Email: _____ Phone: _____

COORDINATION OF BENEFITS

Coverage through another health benefit plan or provincial plan

Do you or your dependents have drug coverage through another health benefits, insurance company or provincial plan? Yes No

If yes, provide the following: Name of plan member: _____

Policy/Plan number: _____ Certificate number: _____

Patient assistance program

Have you enrolled in a patient assistance program? Yes No

If yes, provide your patient assistance program ID number: _____

Provide the patient assistance program:

Contact name: _____ Phone: _____

PART 2: TO BE COMPLETED BY YOUR DOCTOR (PHYSICIAN)

Physician Information

First name: _____ Last name: _____

License: _____ Phone: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Physician's signature: _____

(confirming the below information to be correct)

Drug being requested through Special Authorization

NOTE: Coverage will not be provided for cosmetic purposes

New request Request for continuation of therapy

DIN: _____ Product name: _____

Strength: _____ Dosage: _____

Site of Administration

Home Private clinic Hospital
 Doctor's office Cancer centre LTC facility

CLINICAL INFORMATION

Diagnosis

- Blepharospasm
- Dynamic equinus foot deformity
- Cervical dystonia (spasmodic torticollis), to reduce the severity of abnormal head position and neck pain
- Strabismus
- Upper and/or lower limb focal spasticity (post-stroke)
- Axillary hyperhidrosis
- Neurogenic detrusor overactivity
- Overactive bladder (idiopathic)
- Chronic migraine

Physician specialty

- Specialist with experience in administering BOTOX treatment
- Specialist with experience in treating patients with upper and/or lower limb spasticity
- Urologist

Criteria for initial coverage, confirm the following:

FOR BLEPHAROSPASM

- Patient is 12 years of age or older; and
- Patient diagnosed with blepharospasm associated with dystonia, benign essential blepharospasm or VII nerve disorders

NOTE: Duration of initial approval is 1 year

FOR DYNAMIC EQUINUS FOOT DEFORMITY

- Patient is 2 years of age or older; and
- Patient diagnosed with dynamic equinus foot deformity due to spasticity from cerebral palsy

NOTE: Duration of initial approval is 6 months (limited to 1 treatment every 12 weeks)

FOR CERVICAL DYSTONIA (SPASMODIC TORTICOLLIS), TO REDUCE THE SEVERITY OF ABNORMAL HEAD POSITION AND NECK PAIN

- Patient is 18 years of age or older; and
- Patients with a diagnosis of cervical dystonia (spasmodic torticollis)

NOTE: Duration of initial approval is 6 months (limited to 1 treatment every 12 weeks)

FOR STRABISMUS

- Patient is 12 years of age or older; and
- Patient is diagnosed with strabismus

NOTE: Duration of initial approval is 1 year

FOR UPPER AND/OR LOWER LIMB FOCAL SPASTICITY (POST-STROKE)

- Patient is 18 years of age or older; and
- Patient has a history of stroke; and
- Patient has moderate to severe spasticity of the upper and/or lower limb; and
- Patient has failed standard management (e.g. physiotherapy and/or oral spasticity agents); or
- Patient requires botulinum toxin type A as an adjunct to physical therapy

NOTE: Duration of initial approval is 6 months (limited to 1 treatment every 12 weeks)

FOR AXILLARY HYPERHIDROSIS

- Patient is 18 years of age or older; and
- Patient has severe primary axillary hyperhidrosis; and
- Patient must have previously failed or be intolerant to topical aluminum chloride hexahydrate after 2 months of treatment

NOTE: Duration of initial approval is 6 months (limited to 1 treatment every 12 weeks)

FOR NEUROGENIC DETRUSOR OVERACTIVITY

- Patient is 18 years of age or older; and
- Patient has neurogenic detrusor overactivity caused by multiple sclerosis or subcervical spinal cord injury; and
- Patient has failed or is intolerant at least one trial of an anticholinergic medication (e.g., darifenacin, fesoterodine, flavoxate, oxybutynin, solifenacin, tolterodine, trospium).
- Patient must be willing and able to self-catheterise

NOTE: Duration of initial approval is 36 weeks

FOR OVERACTIVE BLADDER (IDIOPATHIC)

- Patient is 18 years of age or older; and
- Patient has diagnosis of overactive bladder (idiopathic) and is symptomatic (e.g., urinary incontinence, urgency, frequency); and
- Patient has failed or is intolerant to at least two trials of pharmacologic treatments for overactive bladder (e.g., darifenacin, fesoterodine, oxybutynin, solifenacin, tolterodine, trospium, mirabegron)

NOTE: Duration of initial approval is 1 year (maximum 3 doses/year, at a frequency of no more than once every 12 weeks)

FOR CHRONIC MIGRAINE

- Patient is 18 years of age or older; and
- Patient diagnosed with chronic migraine as defined as ≥ 15 days per month with headache lasting 4 hours a day or longer; and
- Patient has failed at least three oral medications used for prevention of migraine (e.g., beta-blocker, anticonvulsants, antidepressants, calcium channel blockers, flunarizine), or has contraindication or intolerable side effects to at least 3 different medications

NOTE: Duration of initial approval is 6 months

Request for continuation of therapy, confirm the following:

FOR BLEPHAROSPASM

- Patient must maintain adequate response to therapy

NOTE: Duration of continued approval is 1 year

FOR DYNAMIC EQUINUS FOOT DEFORMITY

- Patient must maintain adequate response to therapy

NOTE: Duration of continued approval is 1 year

FOR CERVICAL DYSTONIA (SPASMODIC TORTICOLLIS), TO REDUCE THE SEVERITY OF ABNORMAL HEAD POSITION AND NECK PAIN

- Patient must maintain adequate response to therapy

NOTE: Duration of continued approval is 1 year

FOR STRABISMUS

- Patient must maintain adequate response to therapy

NOTE: Duration of continued approval is 1 year

FOR UPPER AND/OR LOWER LIMB FOCAL SPASTICITY (POST-STROKE)

- Patient must maintain adequate response to therapy (e.g., documented benefit of improved passive and/or active range of motion, muscle tone, or improved gait in the case of lower limb spasticity)

NOTE: Duration of continued approval is 1 year

FOR AXILLARY HYPERHIDROSIS

- Patient must maintain adequate response to therapy

NOTE: Duration of continued approval is 1 year (limited to 2 treatments per year)

FOR NEUROGENIC DETRUSOR OVERACTIVITY

- Patient must maintain adequate response to therapy (i.e., 50% or greater reduction from baseline in urinary incontinence episodes)

NOTE: Duration of continued approval is 1 year (limited to treatment intervals no less than every 36 weeks)

FOR OVERACTIVE BLADDER (IDIOPATHIC)

- Patient must maintain adequate response to therapy (e.g., 50% or greater reduction from baseline in urinary incontinence episodes)

NOTE: Duration of continued approval is 1 year (maximum 3 doses/year, at a frequency of no more than once every 12 weeks)

FOR CHRONIC MIGRAINE

- Patient must achieve or maintain a 50% reduction in monthly headache frequency since starting therapy

NOTE: Duration of continued approval is 1 year

SPECIAL NOTES

Describe any intolerances to therapy: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information that the physician believes is important to this review? _____

Date: January 2022