

Special Authorization Request Form, for:

XEOMIN (*incobotulinumtoxin 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
- Upper limb focal spasticity
- Cervical dystonia (spasmodic torticollis), to reduce the severity of abnormal head position and neck pain
- For management of patients with chronic sialorrhea

Physician specialty

- Specialist with experience in administering botulinum toxin treatment
- Physician experienced in treating neurologic conditions

CLINICAL INFORMATION (cont.)

Criteria for initial coverage, confirm the following:

FOR BLEPHAROSPASM

- Patient is 18 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 UPPER LIMB FOCAL SPASTICITY

- Patient is 18 years of age or older; and
- Patient has moderate to severe spasticity of the 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 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 MANAGEMENT OF PATIENTS WITH CHRONIC SIALORRHEA

- Patient is 2 years of age or older; and

Adults:

- Patient has an underlying neurologic condition associated with chronic severe drooling (e.g., Parkinson's disease, ALS, stroke); and
- Patient has moderate to severe chronic troublesome sialorrhea, defined as:
 - sialorrhea lasting for 3 months or more
 - Drooling Severity and Frequency Scale (DSFS) sum score ≥ 6 ; and
- No presence of dysphagia

Pediatrics (2-17 years of age):

- Patient has an underlying neurologic condition associated with chronic severe drooling (e.g., cerebral palsy, traumatic brain injury); and
- Patient weighs 12 kg or more; and
- Patient has severe chronic troublesome sialorrhea for 3 months or more, defined as a modified teacher's drooling score (mTDS) score of 6 or greater; and
- No presence of dysphagia

NOTE: Duration of initial approval is 4 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 UPPER LIMB FOCAL SPASTICITY

- 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 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 MANAGEMENT OF PATIENTS WITH CHRONIC SIALORRHEA

- Patient must maintain continued evidence of benefit (reduction in severity and/or frequency of sialorrhea)

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? _____

Update: February 2023