

PRIOR AUTHORIZATION PROGRAM REIMBURSEMENT REQUEST FORMPlease fax form to:
1-866-840-1509

For muscle or nerve disorders: Botox (botulinum toxin type A)

Please note that the patient AND physician must complete this form. All fields are mandatory and must be completed. Incomplete forms may result in your application being declined. Please retain a copy of this form for your records.

Instructions:

1. PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS.
2. The patient/plan member must complete section A.
3. Your physician must complete section B. The cost, if any, of completing this form is at the expense of the patient/plan member.
4. Please return the form to your insurance company via Pharmacy Services at TELUS Health Solutions (a service provider of your insurance company) by fax to 1-866-840-1509, OR mail to TELUS Health Solutions, 4141 Dixie Rd. P.O. Box 41154, Mississauga, Ont. L4W 5C9.
5. If you have any questions on the application of this program or the decision on reimbursement, or to inquire on the status of your Reimbursement Request Form, please contact your insurer.

A. Information to be Completed by Patient

Employee or Insured's Name		Drug Card Number	
Patient's Name		Patient's Date of Birth (D/M/Y)	Relationship to Employee/Insured (please circle)
		/ /	Employee Spouse Dependant

Please allow two business days for a response once all information is received and complete. Notification of the results of this request will occur Monday to Friday between 9 am and 4 pm Eastern Time.

Please provide contact information and indicate ONE method of preferred contact for notification of the results:

- e-mail me at: _____
 call me (and leave a message if I'm not there) at: (_____) _____
 fax me at: (____) _____
 contact my pharmacy at pharmacy name: _____ phone no.: (____) _____

I certify that the information provided by me is true, correct and complete to the best of my knowledge. I authorize my insurance company, TELUS Health Solutions (a service provider of my insurance company), their authorized representatives, agents and service providers to use and exchange this information needed for underwriting, administration and paying claims with any person or organization who has relevant information pertaining to this claim including health professionals, institutions and investigative agencies in the event of an audit. I authorize my insurance company and/or TELUS Health Solutions (a service provider of my insurance company) to contact any licensed physician, institution, pharmacy or person who has any records or knowledge of me or my health with respect to this submitted claim.

SIGNATURE OF PATIENT/PARENT/LEGAL GUARDIAN _____ Date (D/M/Y): _____

B. Information to be Completed by Prescribing Physician

Drug Name: _____ Strength: _____ Dose: _____

Botox will be eligible for reimbursement only if the patient satisfies one of the criteria listed below and if the patient does not qualify for coverage under any other drug plan or government mandated program. Use of Botox for other reasons (i.e., including, but not limited to the treatment of wrinkles or frown lines) will not be reimbursed. If the patient is covered under another drug plan or government mandated program, the prior authorization program, as part of your drug benefits, may cover the portion not paid for by the primary plan. However, if "none of the above criteria" is indicated, the patient will not be eligible for reimbursement.

Please indicate if the patient satisfies one or more of the following criteria:

- Patient is 12 years or older and is being treated for strabismus.
 Patient is 12 years or older and is being treated for blepharospasm associated with dystonia, including benign essential blepharospasm.
 Drug is used to reduce the signs and symptoms of cervical dystonia in adults.
 Patient is 2 years or older and is being treated for foot deformity as a result of pediatric cerebral palsy.
 Patient is 18 years or older and is being treated for hyperhidrosis of the axilla.
 Drug is used for the treatment of focal spasticity, including treatment of upper limb spasticity associated with stroke in adults.
 For the treatment of urinary incontinence due to neurogenic detrusor overactivity resulting from neurogenic bladder associated with multiple sclerosis or subcervical spinal cord injury in adults who had an inadequate response to or are intolerant of anticholinergic medications.
 For the prophylaxis of headaches in adults with chronic migraine (≥ 15 days per month with headache lasting 4 hours a day or longer).
 OR
 None of the above criteria applies.

Physician's Name		License Number	Telephone Number	Fax Number
Address		City	Province	Postal Code
Physician's Signature			Date (DD/MM/YYYY)	

The most current version of this form supersedes all prior versions. The form may be modified without notice to you and we reserve the right to accept only the current version.
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