Please send completed forms to MHCSI:
Fax: 1-902-481-7114 **E-Mail:** professionalservices@mhcsi.ca
Mail: 201 Brownlow Avenue, Unit 20, Dartmouth, NS B3B 1W2

MHCSI PRIOR AUTHORIZATION FORM – BOTOX/XEOMIN (INITIAL REQUEST)

BOTULINUM TOXIN TYPE A / INCO BOTULINUM TOXIN A

Strictly confidential. This form must be completed in **FULL** and submitted to MHCSI to permit authorization for coverage of a biologic response modifier/specialty medication on your employer-sponsored drug plan. Coverage will be granted if criteria are met and this class of medication is a benefit of your plan. Please contact MHCSI for details of the criteria for these medications. Approvals may be subject to quantity or dollar limits as per plan design.

TO BE COMPLETED BY EMPLOYEE - PATIENT INFORMATION

Member Name :	Group #	Certificate or Client ID #
Mailing Address:	City:	
Province:	Postal Code:	Phone # ( ) Daytime Phone # (if different than above):
Patient Name:		Date of Birth: (DD/MM/YYYY)

Do you or any dependents have other coverage under any other plan ☐ No ☐ Yes **(If Yes, complete the following)**

Name of other Insurer:_____ Member Name: _____

ID #: _____ Policy #: _____

Is this drug covered by coordinating plan? ☐ No ☐ Yes

Are you enrolled in a manufacturer patient assistance program? ☐ No ☐ Yes (program name)_____

*** IMPORTANT, this section of form must be completed in order to avoid processing delays***

You are enrolled in a preferred pharmacy network benefit plan (PPN). Available PPN pharmacies where this medication can be purchased include Lawtons Drugs, Sobeys Pharmacy; Sobeys Pharmacy by Mail, Safeway Pharmacy, FreshCO Pharmacy, Thrifty Foods Pharmacy, Foodland Pharmacy and Rexall Pharmacy Ontario & Vancouver Island.

☐ **My PPN pharmacy location is:** _____ ☐ I choose not to use a PPN pharmacy. Reason: _____

Note: Access to some covered specialty medications may be limited to select pharmacy providers.

I hereby authorize any licensed prescriber, other healthcare professional, institution, insurance company, patient access program, plan sponsor/administrator and MHCSI to exchange information in connection with this claim for the purpose of Prior Authorization evaluation, adjudication of claims, and administration of my drug benefit program. A photocopy of this authorization shall be as valid as the original. I certify that the information in this form is true and complete.

Signature (patient 14 yr. and older/parent/legal guardian) **X**	**Date:** (DD/MM/YYYY)

TO BE COMPLETED BY SPECIALIST – MEDICATION/DIAGNOSTIC INFORMATION FOR INITIAL COVERAGE

Botulinum Toxin Type A ☐ Botox 100iu/ml Inj DIN - 01981501	**Inco Botulinum Toxin Type A** ☐ Xeomin 50iu/ml Inj DIN 02371081 ☐ Xeomin 100iu/ml Inj DIN 02324032	Patient's Body Weight: kg
Requested Dose and Interval	Anticipated treatment duration:	
Facility where injection will be administered:		

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TO BE COMPLETED BY SPECIALIST – CLINICAL INFORMATION FOR INITIAL COVERAGE

INDICATION – *including clinical information*

☐ **Axillary Hyperhidrosis**

Information regarding the severity of the hyperhidrosis

☐ Major functional and psychosocial impact
Describe observed effects: _____

☐ No major (or light to moderate) functional or psychosocial impact

Summary of previous attempt with an aluminum chloride preparation:

Concentration of preparation tried: _____ % ☐ Ineffectiveness ☐ Intolerance ☐ Contraindication ☐ Other

Details: _____

☐ **Blepharospasm**

☐ **Cervical Dystonia**

☐ **Chronic Migraine**
- Number of days of headaches per month _____/month
- Duration of headaches _____ hrs./days
- Was treatment of prophylactic therapy tried?
  ☐ Yes ☐ No (if no, provide reason): _____
  _____

☐ **Focal Spasticity** including the treatment of spasticity in upper limbs associated with cerebrovascular accident

☐ **Foot deformity** resulting from infantile cerebral palsy

☐ **Strabismus**

☐ **Urinary incontinence** caused by neurogenic detrusor or overactive bladder
- Average weekly frequency of urinary continence episodes: _____

☐ **Other** (please specify): _____
_____
_____

MEDICATIONS TRIED (required for initial coverage)

Drug/Treatment	Dose and Frequency	Response to Treatment	Intolerance/Side Effect(s) or Contraindications

☐ Approved Extension Possible ☐ Yes ☐ No

☐ Declined DECLINE CODE:_____

Prescribing Physician: Please note this patient is enrolled in a preferred pharmacy network benefit plan (PPN). Available PPN pharmacies where this medication can be purchased include Lawtons Drugs; Sobeys Pharmacy; Sobeys Pharmacy by Mail; Safeway Pharmacy; FreshCO Pharmacy; Thrifty Foods Pharmacy Foodland Pharmacy and Rexall Pharmacy Ontario & Vancouver Island.

PRESCRIBING SPECIALIST	DISPENSING PHARMACIST
Name and Mailing Address: Phone: _____ Fax:_____	Name, Store & Contact Information: Phone: _____ Fax:_____

MHCSI OFFICE USE

☐ Approved Extension Possible ☐ Yes ☐ No ☐ Declined DECLINE CODE:_____	**Notes:**
Date: / Ph.C.:	
Approved Date Range:	

Quantity	Processing Number:	
PPN Only: ☐ Yes ☐ No PPN Dispensing Pharmacy Called: ☐ Yes ☐ No		