145 The West Mall, P.O. Box 110 U
Toronto, ON M8Z 5M4

PRIOR AUTHORIZATION PROGRAM FORM

Botox® (Onabotulinum Toxin Type A) Neuromuscular Paralytic Agent

Instructions:

1. Section 1 to be completed by Plan Member / Patient
2. Section 2 to be completed by Physician (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist

Please fax completed form to NexgenRx Formulary Management 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario, M8Z-5M4

Section 1: To be completed by Patient

Member's Name: (Last , First)	Card ID Number:																				
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Member (please circle) Employee Spouse Dependent	PATIENT CODE		
---	---	---	---	---	---

Results of this request to be communicated to:

☐ Pharmacy	☐ Patient / Legal Guardian Named Below	☐ email:

I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

Patient / Legal Guardian Name: _____ Telephone Number: _____

Signature of Patient/ Legal Guardian: _____ Date (dd/mm/yy):_____

Section 2: To be completed by Physician

Drug Name & Strength:	DIN:	Dosage Instructions:

Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.

Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

- ❑ To reduce the subjective symptoms and objective signs of cervical dystonia (spasmodic torticollis) in adults.
- ❑ For the treatment of blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorders (Ages 12 or older).
- ❑ For the treatment of strabismus in patients 12 years of age or older.
- ❑ For the treatment of dynamic equinus foot deformity due to spasticity in cerebral palsy (patients 2 years or older).
- ❑ For the treatment of hyperhidrosis of the axillae in patients 18 years of age and older.
- ❑ Management of focal spasticity including upper limb spasticity associated with stroke in adults.
- ❑ Prophylaxis of headaches in adults with chronic migraine (≥ at least 15 days per month with headache lasting 4 hours/day or longer).
- ❑ For the treatment of urinary incontinence due to neurogenic detrusor over activity associated with MS or sub cervical spinal cord injury in adults who had an inadequate response or are intolerant to anticholinergic medication.
- ❑ For the treatment of overactive bladder with symptoms of urinary incontinence, urgency, and frequency, in adult patients who have an inadequate response to or are intolerant of anticholinergic medication.

Physician Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Physician:	Date (dd/mm/yy)

Section 3: To be completed by Pharmacist

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Pharmacist: _____ Pharmacist's Name: (Print Last, First)	

Internal Office Use Only:

Date Received:			Date Approved & By: