AGA BENEFIT SOLUTIONS

INFORMATION DRUG REQUEST
DRUG REQUIRING PRIOR AUTHORIZATION

BOTOX (Onabotulinumtoxina) **DYSPORT** (Abobotulinumtoxina) **XEOMIN** (Incobotulinumtoxina)

SECTION 1 – INFORMATION ON THE MEMBER

Member name:	Group number:	Certificate number:
Address (No. / Street / Apt.):		
City :	Province :	Postal Code :
Phone number :	E-mail address :	
Employer name / Policy holder: :	Group / Division number:	

SECTION 2 – INFORMATION ON THE PATIENT

Patient name:	
Patient Date of Birth (YYYY/MM/DD):	Relationship to member:

Have you applied for coverage with a provincial program? ☐ YES ☐ NO

Has your application for coverage with the provincial program for this drug or supply been approved? ☐ YES ☐ NO

If you have applied for coverage with a provincial program, please provide us with a copy of the refusal or acceptance letter.

Are you enrolled in a drug manufacturer's patient assistance program? ☐ YES ☐ NO

If yes, please provide your patient assistance program identification number: _____

SECTION 3 - AUTHORIZATION TO SHARE PERSONAL INFORMATION

I authorize any health professional (doctor, pharmacist, dentist), any person (service provider), any other insurance company, any public or private health institution, any government agency in relation to health or social services, to disclose and exchange requested information by the insurer or AGA Benefits Solutions, necessary for the evaluation of my request for prior authorization for that drug.

Patient signature:	Date:
Signature of the subscriber when patient is a minor:	Date:

SECTION 4 - DRUG COVERED BY THE APPLICATION

Drug Name:		
Dosage:		
Pharmaceutical Form:		Content / Strength:
Anticipated duration of treatment:	From (YYYY/MM/DD) :	To (YYYY/MM/DD) :
Diagnosis:		Initial date of diagnosis (YYYY-MM-DD):

Medication will be administered at the following location:

☐ Home ☐ Health and social service center ☐ Long-term care center ☐ Private clinic

☐ Hospital - internal patient ☐ Hospital - external patient ☐ Elsewhere. Specify : _____

If the treatment is not administered at home, please provide the following information:

Name of the location where the drug will be administered:		Telephone:	
Address (No. / Street / Apt.):	City :	Province:	Postal Code :

SECTION 5 - TYPE OF APPLICATION

☐ Initial request	☐ Continued treatment	☐ Modification of treatment

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SECTION 6- SUMMARY OF PREVIOUS TRIALS OR CONTRAINDICATIONS

Please provide a list of medicines and/or treatments used to date to control this condition:

Name of drug/treatment currently or previously prescribed	Content - strength / Dosage	Trial Period From (YYYY-MM-DD)	Trial Period To (YYYY-MM-DD)	Reason for Discontinuation
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other (specify) : _____
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other (specify) : _____
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other (specify) : _____
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other (specify) : _____
				☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other (specify) : _____

SECTION 7 - CLINICAL INFORMATION SPECIFIC TO THIS APPLICATION

DIAGNOSTIC

☐ Cervical dystonia ☐ Strabismus ☐ Blepharospasm ☐ Equinus Foot ☐ Migraines

☐ Axillary hyperhidrosis ☐ Focal Spasticity ☐ Overactive bladder

☐ Neurogenic detrusor overactivity associated with neurological condition

☐ Other severe spasticity condition(s). Please specify : _____

☐ Other therapeutic indication(s). Please specify : _____

BLEPHAROSPASM

Does the patient have any of the following conditions?

☐ Benign essential blepharospasm

☐ Dystonia

☐ VII nerve disorder

MIGRAINES

Number of days with headaches within a month : ☐ less than 4 days ☐ between 4 and 14 days ☐ 15 days or more

Number of migraines per month : _____

Have these symptoms been present for more than 3 months? ☐ Yes ☐ No

Do the headaches last at least 4 hours? ☐ Yes ☐ No

Headache Impact Test (HIT-6) result : _____ Date of result (YYYY/MM/DD) : _____

Will the treatment be administered in combination with another treatment for the prevention of migraines? ☐ Yes ☐ No

If so, specify which treatment : _____

Please indicate the areas to be injected with desired dosage in units :

_____

SEVERE AXILLARY HYPERHIDROSIS

Please specify the degree of impairment on the functional and psychosocial levels : ☐ Mild ☐ Moderate ☐ Severe

Please describe the impairment observed : _____

Please indicate if the patient has used Drysol: ☐ Yes ☐ No If yes, indicate the strength: ☐ 20% ☐ 12% ☐ 6,25%

FOCAL SPASTICITY

Does the patient have focal spasticity of the upper or lower limbs? ☐ Upper ☐ Lower

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SECTION 7 - CLINICAL INFORMATION SPECIFIC TO THIS APPLICATION

OVERACTIVE BLADDER

Please check the patient's symptoms:

☐ Urgency ☐ Daytime urinary frequency ☐ Stress urinary incontinence ☐ Urge urinary incontinence

NEUROGENIC DETRUSOR OVERACTIVITY

Is the detrusor overactivity associated with multiple sclerosis? ☐ Yes ☐ No

Is the detrusor overactivity associated with sub cervical spinal cord injury? ☐ Yes ☐ No

SECTION 8 - CLINICAL INFORMATION REGARDING RENEWAL

MIGRAINES

Frequency of headaches was reduced by : ☐ 0 à 24% ☐ 25 à 49% ☐ 50 à 74% ☐ 75 à 100%

Please provide the current HIT-6 result : _____ Date of test (YYYY/MM/DD): _____

SEVERE AXILLARY HYPERHIDROSIS

Decrease in sudation: ☐ Yes ☐ No

Please describe the beneficial effect observed: _____

_____

Improvement on the functional and psychosocial levels: ☐ Yes ☐ No

Please describe the beneficial effect observed: _____

_____

SECTION 9– ADDITIONAL INFORMATION (optional)

SECTION 10 – SIGNATURE OF AUTHORIZED PRESCRIBER

Print name of authorized prescriber:	Specialty of the physician:	
Signature of authorized prescriber:	License Number:	Date :

SECTION 11 - IMPORTANT PATIENT INFORMATION

Fees may be charged to complete this form, it is the patient's responsibility to pay them.
Ensure all required sections of the form have been completed and signed before returning it.
Attach any additional documents required on this form.
Your request may be delayed if we do not have all the necessary information.
The drug will be eligible only if it meets the criteria established by the insurer.

HOW TO RETURN THE FORM

By email : **exceptions@aga.ca** By fax: (514) 935-1147	By mail : AGA Benefit Solutions 3500 de Maisonneuve Blvd. W, suite 2200 Westmount (QC) H3Z 3C1