Manulife

Group Benefits
Drug Prior Authorization

Botox (OnabotulinumtoxinA)

The purpose of this form is to obtain the medical information required to assess your request for a drug on the Prior Authorization list under your drug plan benefit coverage. To avoid delays in processing your request, please ensure that all information, including contact information is complete. Completion of this form is not a guarantee of approval. If you have already purchased the drug, please attach all original receipts along with an Extended Health Care Claim form. All costs incurred to complete this form are the plan member's responsibility. If you are registered for the Plan Member Secure Site and have provided an email address, you will receive an email notification when the prior authorization decision is available on your claims statement. If you are not registered on the Plan Member Secure Site, you will be notified of the prior authorization decision by mail.

Important: Please ensure the most current unaltered version of the form is completed and signed. To download the most recent version of the Drug Prior Authorization form go to www.manulife.ca

1 Plan member and patient information

To be completed by plan member

Plan contract number	Plan member certificate number	Plan sponsor

Plan member name (first, middle initial, last)	Date of birth (dd/mmm/yyyy)

Plan member address (number, street and apt.)	City or town	Province	Postal code

Patient name (first, middle initial, last)	Patient date of birth (dd/mmm/yyyy)	Relationship to plan member

Patient's preferred daytime phone number	Patient's email address (optional)

Does the patient have drug coverage under any other group plan? ◯ Yes ◯ No

If Yes,

Name of insurance company	
Plan contract number	Plan member certificate number

Is this drug covered under the other group plan? ◯ Yes ◯ No

If no, why was the drug declined by the other group plan? Please attach the other group plan decline notice (typically a letter or statement). We need this decline notice to see if this drug can be approved.

Did your plan sponsor recently transfer your drug benefits to Manulife? ◯ Yes ◯ No

2 Provincial Plans

To be completed by prescribing physician

Most provinces offer some form of drug coverage to their residents. Your Manulife drug plan supplements the coverage provided by provincial plans. It is important that you or your doctor (if required) apply to the applicable provincial program to ensure there are no delays in your drug reimbursement.
Check with your doctor or login to the **Manulife Provincial Drug Plans Resource Centre** on our Plan Member Secure Site at www.manulife.ca/planmember to confirm if the drug you have been prescribed may be eligible for coverage under a provincial plan. If the drug you have been prescribed is listed under a provincial program, you will need to apply to the program before consideration can be given under your Manulife drug plan.

Has application been made to the provincial program for coverage? ◯ Yes ◯ No

If no, why?

Has the patient been approved for coverage by the provincial program for this drug? ◯ Yes ◯ No

If no, advise why the request was declined

In Ontario, for patients that qualify for coverage under the Exceptional Access Program (EAP), if the drug is an EAP drug, a copy of the approval or denial from EAP must be submitted with this form so Manulife can complete the assessment of this request.

3 Patient Assistance Programs

To be completed by plan member

Have you enrolled in the Patient Assistance Program? ◯ Yes ◯ No

If Yes, please provide your Patient Assistance Program ID Number:

Case Manager name and contact details

4 Medical information

To be completed by prescribing physician

Drug strength and dosage

Where will the treatment be administered?

◯ Home ◯ MD Office ◯ Private Clinic ◯ Hospital/In-patient ◯ Hospital/Out-patient

Is there a medical reason why this drug needs to be administered in a hospital setting? ◯ Yes ◯ No

If Yes, explain below.

Are there any adjunctive services performed at the time of administration of this injection? ◯ Yes ◯ No

If Yes, explain below.

Is the MD office located in a hospital? ◯ Yes ◯ No

Will the drug be administered in the MD office or in another area of the hospital? (describe below)

If the treatment is **not** being administered at home, please provide:

Name of private clinic/hospital			Telephone number
Address (number, street and apt.)	City or town	Province	Postal code

4 Medical information (continued)

To be completed by prescribing physician

Please select the diagnosis for which the drug has been prescribed and respond to the corresponding questions.

◯ Blepharospasm

Will the dosage exceed 400 Units in a 3-month (90 days) interval? ◯ Yes ◯ No

If Yes, please provide the prescribed dosage in number of Units in a 3-month interval and rationale for prescribing a higher dosage.

Will the drug be administered by a physician with the appropriate qualifications and experience in the treatment and the use of required equipment? ◯ Yes ◯ No

◯ Cervical Dystonia

Will the dosage exceed 400 Units in a 3-month (90 days) interval? ◯ Yes ◯ No

If Yes, please provide the prescribed dosage in number of Units in a 3-month interval and rationale for prescribing a higher dosage.

Will the drug be administered by a physician with the appropriate qualifications and experience in the treatment and the use of required equipment? ◯ Yes ◯ No

◯ Focal Spasticity

Will the dosage exceed 400 Units in a 3-month (90 days) interval? ◯ Yes ◯ No

If Yes, please provide the prescribed dosage in number of Units in a 3-month interval and rationale for prescribing a higher dosage.

Will the drug be administered by a physician with the appropriate qualifications and experience in the treatment and the use of required equipment? ◯ Yes ◯ No

◯ Hyperhidrosis of the Axillae

Will the dosage exceed 400 Units in a 3-month (90 days) interval? ◯ Yes ◯ No

If Yes, please provide the prescribed dosage in number of Units in a 3-month interval and rationale for prescribing a higher dosage.

Will the drug be administered by a physician with the appropriate qualifications and experience in the treatment and the use of required equipment? ◯ Yes ◯ No

◯ Strabismus

Will the dosage exceed 400 Units in a 3-month (90 days) interval? ◯ Yes ◯ No

If Yes, please provide the prescribed dosage in number of Units in a 3-month interval and rationale for prescribing a higher dosage.

Will the drug be administered by a physician with the appropriate qualifications and experience in the treatment and the use of required equipment? ◯ Yes ◯ No

◯ Equinus Foot Deformity

Has the patient been formally diagnosed with cerebral palsy? ◯ Yes ◯ No

Will the dosage exceed 400 Units in a 3-month (90 days) interval? ◯ Yes ◯ No

If Yes, please provide the prescribed dosage in number of Units in a 3-month interval and rationale for prescribing a higher dosage.

Will the drug be administered by a physician with the appropriate qualifications and experience in the treatment and the use of required equipment? ◯ Yes ◯ No

◯ Chronic Migraine

Does the patient have a confirmed diagnosis of chronic migraine defined as headaches on at least 15 days per month for more than 3 months of which at least 8 days per month are with migraine? ◯ Yes ◯ No

Is Botox being prescribed by or in consultation with a physician experienced in the diagnosis and treatment of migraine? ◯ Yes ◯ No

Has the patient tried and failed or were they unable to tolerate (due to side effects) or had an inadequate response to a 6-week trial to at least two of the drugs/drug classes listed below:

- Topiramate? ◯ Yes ◯ No
- Divalproex sodium/valproate sodium? ◯ Yes ◯ No
- Beta-blocker (metoprolol, propranolol, timolol, atenolol, nadolol)? ◯ Yes ◯ No
- Tricyclic antidepressant (amitriptyline, nortriptyline)? ◯ Yes ◯ No
- Serotonin-norepinephrine reuptake inhibitor (venlafaxine, duloxetine)? ◯ Yes ◯ No
- Angiotensin receptor blocker (candesartan)? ◯ Yes ◯ No

Will the dosage exceed 400 Units in a 3-month (90 days) interval? ◯ Yes ◯ No

If Yes, please provide the prescribed dosage in number of Units in a 3-month interval and rationale for prescribing a higher dosage.

Will the drug be administered by a physician with the appropriate qualifications and experience in the treatment and the use of required equipment? ◯ Yes ◯ No

Note* Section 5 - Drug History must be completed, if not the request will be considered incomplete and the review will not proceed.

◯ Neurogenic Detrusor Overactivity

Is the urinary incontinence due to multiple sclerosis? ◯ Yes ◯ No

Is the urinary incontinence due to a spinal cord injury? ◯ Yes ◯ No

Will the dosage exceed 400 Units in a 3-month (90 days) interval? ◯ Yes ◯ No

If Yes, please provide the prescribed dosage in number of Units in a 3-month interval and rationale for prescribing a higher dosage.

Will the drug be administered by a physician with the appropriate qualifications and experience in the treatment and the use of required equipment? ◯ Yes ◯ No

◯ Overactive Bladder

Is the patient experiencing urinary incontinence, urgency and frequency? ◯ Yes ◯ No

Will the dosage exceed 400 Units in a 3-month (90 days) interval? ◯ Yes ◯ No

If Yes, please provide the prescribed dosage in number of Units in a 3-month interval and rationale for prescribing a higher dosage.

Will the drug be administered by a physician with the appropriate qualifications and experience in the treatment and the use of required equipment? ◯ Yes ◯ No

◯ Treatment of Lower Limb Spasticity Associated with Stroke

Has the patient experienced a stroke? ◯ Yes ◯ No

Does the patient have ankle spasticity on a Modified Ashworth Scale of ≥2? ◯ Yes ◯ No

Will the dosage exceed 400 Units in a 3-month (90 days) interval? ◯ Yes ◯ No

If Yes, please provide the prescribed dosage in number of Units in a 3-month interval and rationale for prescribing a higher dosage.

Will the drug be administered by a physician with the appropriate qualifications and experience in the treatment and the use of required equipment? ◯ Yes ◯ No

◯ Any other diagnosis

Please provide the specific diagnosis and any Canadian clinical research that supports the use of this drug in your patient's context.

5 Drug history

To be completed by prescribing physician

If no previous therapies have been tried for the selected diagnosis, please specify the rationale:

◯ Risk of drug interaction ◯ Patient has contraindication

◯ Other

Please provide medical rationale

For the selected diagnosis, please provide all previous and current drug therapies in the area below.

Drug name	Start date (yyyy/mmm)	End date (yyyy/mmm)

Please specify the outcome: ◯ Intolerance (Allergy/Adverse Event) ◯ Inadequate/Suboptimal Response

Will the patient be continuing on this medication in addition to new therapy? ◯ Yes ◯ No

Drug name	Start date (yyyy/mmm)	End date (yyyy/mmm)

Please specify the outcome: ◯ Intolerance (Allergy/Adverse Event) ◯ Inadequate/Suboptimal Response

Will the patient be continuing on this medication in addition to new therapy? ◯ Yes ◯ No

Drug name	Start date (yyyy/mmm)	End date (yyyy/mmm)

Please specify the outcome: ◯ Intolerance (Allergy/Adverse Event) ◯ Inadequate/Suboptimal Response

Will the patient be continuing on this medication in addition to new therapy? ◯ Yes ◯ No

6 Physician information

To be completed by prescribing physician

Prescribing physician's name	Specialty

Address (number, street and suite)	City or town	Province	Postal code

Telephone number	Extension	Fax number

Physician authorization

I certify that the information in this form is true and complete to the best of my knowledge. The information in this statement will be kept in a Group Benefits health file with Manulife and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.

Physician's signature	Date signed (dd/mmm/yyyy)

7 Authorization and Plan member signature

To be signed by plan member

I confirm that

- I, or one of my family members covered by my plan, need the drug named on this form (or an equivalent drug that Manulife proposes)
- the information I have given you in this request is true and complete

I agree that Manulife can collect, use, keep, and share my personal information, or the personal information of my family members, to manage this claim.

I agree that Manulife can also use this information for these purposes:

- managing my group benefits plan
- assessing and processing claims
- investigating and ensuring the quality and accuracy of claims
- patient assistance programs, if they apply

I agree that these people and groups can share my personal information with Manulife to manage my claim:

- medical and health professionals, such as my doctor, Manulife's doctor, pharmacist and nurse
- health providers, such as pharmacies, preferred pharmacies, hospitals, clinics, patient assistance programs
- Manulife's service providers

If my Manulife plan requires me to buy a drug that needs prior authorization from a preferred pharmacy or provider, a case manager may contact me, my doctor and/or Patient Assistance Program to:

- give me information about the program
- arrange to have my prescription or authorization transferred to the preferred pharmacy or provider

I agree that Manulife can use my Social Insurance Number ("SIN") to identify me and manage my benefits, if my SIN is used as my plan member certificate number.

I agree that a photocopy or electronic version of this authorization is valid.

Plan member's signature	Date signed (dd/mmm/yyyy)

Protecting your personal information is important to us. People who can see your personal information are:

- Manulife employees who need to see your information to do their jobs
- people you've given permission to

To find out more about Manulife's privacy policy please see manulife.ca

8 Mailing instructions

Use the Submit a Claim Feature on the Plan Member Secure Site
OR mail or fax your completed form to the appropriate address:

If you live in Quebec:

Manulife Group Benefits Health Claims
Attention Prior Authorization Team
PO BOX 2580, STATION B
MONTREAL QC H3B 5C6

Fax: 1-855-752-0404

If you live outside Quebec:

Manulife Group Benefits Health Claims
Attention Prior Authorization Team
PO BOX 1653
WATERLOO ON N2J 4W1

Fax: 1-855-752-0404

Please retain a photocopy for your files.