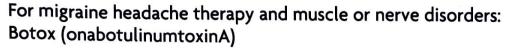
Prior Authorization Form





Sun Life Assurance Company of Canada, a member of the Sun Life Financial group of companies, is committed to keeping your information confidential.

1 Important – please read carefully

Please note that the completion of this form is not a guarantee of approval. It must be completed in full otherwise it will be returned to you. Any expense for medical evidence to support this request is your responsibility. Given the confidential nature of your information, we will issue our response to you in writing.

If you have already purchased the medication for which you are requesting prior authorization, please attach all original receipts along with a regular extended health care claim form.

2	To be comp	leted by	plan member

Contract number	Mem	ber ID numbe	er ID number Your plan sponsor/employe		r			
Your last name			First name				☐ Male ☐ Female	Date of birth (dd-mm-yyyy)
Your address (street number	and name)							Apartment or suite
City					Province			Postal code
Preferred language of corres ☐ English ☐ French	pondence		ohone number			Fax n	umber	_

Claimant information

Claimant's last name	First name
Date of birth (dd-mm-yyyy)	Relationship to plan member ☐ Self ☐ Spouse ☐ Child

Authorization and signature

I certify that the information I provided above is true and complete. I authorize Sun Life Assurance Company of Canada, its agents and service providers to collect, use and disclose information needed for underwriting, administration and adjudicating claims under this Plan with any person or organization who has relevant information pertaining to this application including health professionals, institutions, investigative agencies, insurers and reinsurers.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original.

Plan member's signature	Date (dd-mm-yyyy)
X	2002 CONSTRUCTOR



PAE

y prescribing physician				
Prescribing physician's last name (please print)	First name (please print)			
Specialty		Telephone number		
Address (street number and name)		Apartment or suite		
City	Desta			
	Province	Postal code		
Drug name	Strength	Dose		
Botox (onabotulinumtoxinA) will be eligible of the criteria listed below. Use of Botox (olimited to the treatment of wrinkles or frow any of the criteria, then the drug will not be last box below). The eligible expense under available under a government-sponsored drawn of the criteria.	nabotulinumtoxinA) for other in the lines) will not be reimbursed the eligible for reimbursement (plants) of the this plants that portion of the	reasons (i.e., including, but not l. If the patient does not satisfy lease confirm by checking off the		
If approved, approval for coverage of this d Company of Canada's discretion.	lrug may be reassessed at any ti	me at Sun Life Assurance		
Please indicate if the patient satisfies one of	r 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 benign essential blepharospasm. 	treated for blepharospasm asso	ociated with dystonia, including		
☐ 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 r	esult 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 associat with stroke in adults. 				
 For the treatment of urinary incontiner neurogenic bladder associated with mu an inadequate response to or are intole 	ltiple sclerosis or subcervical sr	pinal cord injury in adults who had		
☐ For the prophylaxis of headaches in ad lasting 4 hours a day or longer).	ults with chronic migraine (≥ 1)	5 days per month with headache		
☐ For the treatment of overactive bladder in adult patients who have an inadequate	with symptoms of urinary inco ate response to or are intoleran	ontinence, urgency, and frequency,		
OR		or and an analysis in careation.		
☐ None of the above criteria applies.				
Relevant additional information				
Physician's signature		Date (dd-mm-yyyy)		
X		(ad-IIIII-yyyy)		

Respecting your privacy

Your privacy is important to us. We may leverage our strengths in our worldwide operations and in our negotiated relationships with third-party providers to help us service some of our customers. In some instances our employees, service providers, agents, reinsurers and any of their service providers, may be located in jurisdictions outside Canada, and your personal information may be subject to the laws of those foreign jurisdictions.

To find out about our Privacy Policy, visit our website at www.sunlife.ca, or to obtain information about our privacy practices, send a written request by email to privacyofficer@sunlife.com, or by mail to Privacy Officer, Sun Life Financial, 225 King St. West, Toronto, ON M5V 3C5.

Questions? Please visit www.sunlife.ca or call our toll-free number 1-800-361-6212 Monday - Friday, 8 a.m. - 8 p.m. ET

Mailing instructions – keep a copy for your records

Mail or fax your completed form to the claims office nearest you.

Fax number: 1-855-342-9915

Sun Life Assurance Company of Canada PO Box 11658 Stn CV Montreal QC H3C 6C1 Sun Life Assurance Company of Canada PO Box 2010 Stn Waterloo Waterloo ON N2J 0A6