PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

BOTOX®, XEOMIN®, DYSPORT THERAPEUTIC™ NON-MIGRAINE INDICATIONS 2 YEAR APPROVAL

⊘ PLEASE DO NOT STAPLE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2689 | Toll-free fax: 1 844 419-2689 | pac.bluecross.ca

HOW TO COMPLETE THIS FORM:
PLAN MEMBERS — Please complete RED portions of this form.
PHYSICIANS — Please complete BLACK portions of this form.

Don't forget to sign *Part 7 — Member Consent and Declaration* before you submit your claim.

The patient is responsible for any fees charged by the physician for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.

Completion of this form does NOT imply approval for this drug. Coverage is based on the provisions of your Extended Health Care plan and Pacific Blue Cross qualification criteria.

☐ **Patient has PharmaCare Special Authority Approval (Please attach document)**

PART 1 — PLAN MEMBER TO COMPLETE

Plan member's name		Patient's name (if different than Plan member's name)			
Patient's birthdate (mm-dd-yyyy)	Policy number	ID number			
Street address	City	Province	Postal code	Daytime phone number (10 digits)	

PART 2 — PHYSICIAN TO COMPLETE

Physician's name	College ID		
Street address	City	Province	Postal code

Physician's area of specialty (if applicable): _____

I have a Collaborative Prescribing Agreement for Botox®, Dysport™ and Xeomin® with BC PharmaCare: ☐ Yes ☐ No (attach copy of CPA if yes)

I certify the medical information provided is accurate and current:

Physician's signature **X**	Date (mm-dd-yyyy)

PART 3 — DRUG REQUEST INFORMATION

Drug name	Strength	Dosage	Duration of therapy	Year of diagnosis

PART 4 — DIAGNOSIS

BOTOX® (ONABOTULINUMTOXIN A) — If requesting for migraine prevention, please see Migraine Prevention Form. Otherwise, please select one from the following:

☐ Treatment of Blepharospasm in patient 12 years of age or older
☐ Treatment of Strabismus in patient 12 years of age or older
☐ Reduce symptoms and signs of Cervical Dystonia (spasmodic torticollis) in adult
☐ Management of Focal Spasticity in adult
☐ Treatment of Equinus Foot Deformity in patient 2 years of age or older
☐ Treatment of Primary Hyperhidrosis of Axillae in adult
☐ Treatment of Neurogenic Detrusor Overactivity associated with neurological condition in adult (urinary incontinence)
☐ Treatment of Overactive Bladder in adult with inadequate response or intolerance of anticholinergic medication
☐ Other (please specify):

_____

_____

XEOMIN® (INCOBOTULINUMTOXIN A) — Please select one from the following:

☐ Treatment of Blepharospasm in adult
☐ Reduce symptoms and signs of Cervical Dystonia (spasmodic torticollis) in adult
☐ Treatment of Upper Limb Spasticity associated with stroke in adult
☐ Management of Focal Spasticity in adult
☐ Other (please specify):

_____

_____

DYSPORT THERAPEUTIC™ (ABOBOTULINUMTOXIN A) — Please select one from the following:

☐ Reduce symptoms and signs of Cervical Dystonia (spasmodic torticollis) in adults
☐ Symptomatic treatment of Focal Spasticity affecting upper limbs and lower limbs in adults
☐ Symptomatic treatment of Lower Limb Spasticity in pediatric patients 2 years of age and older
☐ Other (please specify):

_____

_____

_____

PART 5 — DRUGS CURRENTLY OR PREVIOUSLY PRESCRIBED FOR CONDITION

Drug 1	Name	Strength	Dosage	Duration of therapy
If discontinued, please state reason				
Drug 2	Name	Strength	Dosage	Duration of therapy
If discontinued, please state reason				
Drug 3	Name	Strength	Dosage	Duration of therapy
If discontinued, please state reason				

PART 6 — ADDITIONAL INFORMATION

PART 7 — MEMBER CONSENT AND DECLARATION

IMPORTANT: This section must be signed before submitting your form.

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims.

I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan. I authorize my physician to release my personal information to Pacific Blue Cross to obtain approval for prescription benefit.

Member's signature	Date (mm-dd-yyyy)
X	