Prior Authorization Form

For migraine headache therapy and muscle or nerve disorders: Botox (onabotulinumtoxinA)

Sun Life Financial

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 completed by plan member

Plan member information

Contract number	Member ID number	Your plan sponsor/employer		
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 correspondence ☐ English ☐ French	Daytime phone number _ _	Fax number _ _		

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	_ _

PAE

3 To be completed by 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	Province	Postal code
Drug name	Strength	Dose

Botox (onabotulinumtoxinA) will be eligible for reimbursement only if the patient satisfies one or more of the criteria listed below. Use of Botox (onabotulinumtoxinA) for other reasons (i.e., including, but not limited to the treatment of wrinkles or frown lines) will not be reimbursed. If the patient does not satisfy any of the criteria, then the drug will not be eligible for reimbursement (please confirm by checking off the last box below). The eligible expense under this plan is that portion of the expense that is not payable or available under a government-sponsored drug program or another drug plan.

If approved, approval for coverage of this drug may be reassessed at any time at Sun Life Assurance Company of Canada's discretion.

Please indicate if the patient satisfies one or 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 treated for blepharospasm associated with dystonia, including benign essential blepharospasm.

☐ 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 result 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 associated with stroke in adults.

☐ For the treatment of urinary incontinence due to neurogenic detrusor overactivity resulting from neurogenic bladder associated with multiple sclerosis or subcervical spinal cord injury in adults who had an inadequate response to or are intolerant of anticholinergic medications.

☐ For the prophylaxis of headaches in adults with chronic migraine (≥ 15 days per month with headache lasting 4 hours a day or longer).

☐ 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.

OR

☐ None of the above criteria applies.

Relevant additional information

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

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

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