BRITISH COLUMBIA | Ministry of Health

PHARMACARE SPECIAL AUTHORITY REQUEST

BOTULINUMTOXINA

HLTH 5865 Rev. 2025/09/18

For up-to-date criteria and forms, please check: www.gov.bc.ca/pharmacarespecialauthority

Fax requests to 1-800-609-4884 (toll free) OR mail requests to: PharmaCare, Box 9652 Stn Prov Govt, Victoria, BC V8W 9P4

This facsimile is doctor-patient privileged and contains confidential information intended only for PharmaCare. Any other distribution, copying or disclosure is strictly prohibited.

If PharmaCare approves this Special Authority request, approval is granted solely for the purpose of covering prescription costs. PharmaCare approval does not indicate that the requested device is, or is not, suitable for any specific patient or condition.

If you have received this fax in error, please write MISDIRECTED across the front of the form and fax toll-free to 1-800-609-4884, then destroy the pages received in error.

Forms with information missing will be returned for completion. If no prescriber fax or mailing address is provided, PharmaCare will be unable to return a response.

SECTION 1 – PRESCRIBER'S INFORMATION

Prescriber's Name and Mailing Address	
College ID (use ONLY College ID number)	Phone Number (include area code)
CRITICAL FOR A TIMELY RESPONSE →	Prescriber's Fax Number

SECTION 2 – PATIENT INFORMATION

Patient (Family) Name	
Patient (Given) Name(s)	
Date of Birth (yyyy / mm / dd)	Date of Application (yyyy / mm / dd)
CRITICAL FOR PROCESSING →	Personal Health Number (PHN)

SECTION 3 – Indications EXCLUDING urinary incontinence. See Page 2, Section 4 for urinary incontinence indications

Subject to ALL of the criteria below being met (mark boxes and complete blanks as applicable):

◯ **OnabotulinumtoxinA (Botox®) 9901-0111**

Indication	Initial Requests: 1 Year	Renewal Requests: 3 Year
☐ Focal spasticity Provide injection site(s): _____ _____ ☐ Spasmodic torticollis (cervical dystonia) ☐ Blepharospasm ☐ Strabismus ☐ Equinus foot deformity due to spasticity in pediatric CP patients ≥ 2 yrs of age	Dose requested: _____	Dose requested: _____ Frequency of use: _____ Provide details of benefit seen: _____ _____

◯ **IncobotulinumtoxinA (Xeomin®) 9901-0498**

Indication	Initial Requests: 1 Year	Renewal Requests: 3 Year
☐ Post-stroke spasticity of the upper limb Provide injection site(s): _____ _____ ☐ Spasmodic torticollis (cervical dystonia) ☐ Blepharospasm	Dose requested: _____	Dose requested: _____ Frequency of use: _____ Provide details of benefit seen: _____ _____

◯ **AbobotulinumtoxinA (Dysport®) 9901-0499**

Indication	Initial Requests: 1 Year	Renewal Requests: 3 Year
☐ Focal spasticity Provide injection site(s): _____ _____ ☐ Spasmodic torticollis (cervical dystonia)	Dose requested: _____	Dose requested: _____ Frequency of use: _____ Provide details of benefit seen: _____ _____

Please complete additional information on page 2 >>

Patient (Family) Name	Patient (Given) Name(s)	Personal Health Number (PHN)

SECTION 4 – URINARY INCONTINENCE INDICATIONS - ONABOTULINUMTOXINA (BOTOX®) ONLY 9901-0111

Subject to ALL of the criteria below being met (mark boxes and complete blanks as applicable). Complete Section A + Section B or C

A ***In addition to this information, complete either B or C and the applicable fields for initial or renewal request.***

OnabotulinumtoxinA (Botox®) ONLY 9901-0111 Dose requested: _____ units

Frequency of use: _____

AND

B ◯ **Urinary incontinence due to overactive bladder (OAB) in adult patients when submitted by a UROLOGIST**

◯ **INITIAL COVERAGE: 1 course (maximum 100 units)**

Failure or intolerance with at least 2 appropriate medications (anticholinergics/mirabegron). Provide details below::

Drug 1: _____ Dose: _____ Duration of trial: _____

Response: ☐ Failure ☐ Intolerance (provide details): _____

Drug 2: _____ Dose: _____ Duration of trial: _____

Response: ☐ Failure ☐ Intolerance (provide details): _____

◯ **RENEWAL COVERAGE: 1 course** (coverage is provided for treatment up to 100 units per course at a minumum interval of 12 weeks, up to a maximum of 3 courses per year**)**

Provide the percentage reduction in the frequency of urinary incontinence episodes from baseline: _____%

OR

C ◯ **Urinary incontinence due to neurogenic detrusor overactivity (NDO) in adult patients**

◯ **INITIAL COVERAGE: 1 course (maximum 200 units)**

NDO in patient with: ☐ multiple sclerosis (MS)

☐ subcervical spinal cord injury (SCI) ☐ Other (provide details) _____

PLUS

Failure or intolerance with at least 1 anticholinergic (or mirabegron): Provide details below:

Drug: _____ Dose: _____ Duration of trial: _____

Response: ☐ Failure ☐ Intolerance (provide details): _____

◯ **RENEWAL COVERAGE: 1 year** (coverage is provided for treatment up to 200 units per course at minimum intervals of 36 weeks**)**

Provide the percentage reduction in the frequency of urinary incontinence episodes from baseline: _____%

If not applicable, (i.e., patient is catheterized), provide further details on how response to Botox is measured AND amount of improvement seen:

_____

Report all adverse events to the post-market surveillance program, Canadian Vigilance, toll-free 1-866-234-2345 (health professionals only).

Personal information on this form is collected under the authority of, and in accordance with, the *British Columbia Pharmaceutical Services Act* 22(1) and *Freedom of Information and Protection of Privacy Act* 26 (a),(c),(e). The information is being collected for the purposes of (a) administering the PharmaCare program, (b) analyzing, planning and evaluating the Special Authority and other Ministry programs and (c) to manage and plan for the health system generally. If you have any questions about the collection of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in BC toll free at 1-800-663-7100 and ask to consult a pharmacist concerning the Special Authority process.

I have discussed with the patient that the purpose of releasing their information to PharmaCare is to obtain Special Authority for prescription coverage and for the purposes set out here.

_____

Prescriber's Signature (Mandatory)

PharmaCare may request additional documentation to support this Special Authority request.
Actual reimbursement is subject to the rules of a patient's PharmaCare plan, including any annual deductible requirement, and to any other applicable PharmaCare pricing policy.

PHARMACARE USE ONLY

Status	Effective Date (YYYY / MM / DD)	Duration of Approval

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