DR. HOLOWATY MEDICINE

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Referral form for Botox for Chronic Daily Migraine – page 1 of 2

We will contact your patient directly as well as acknowledging receipt of referral.

For your information, patients are generally only eligible from their insurance provider for botox for chronic daily migraine if the following conditions have been met:

- Secondary headache causes have been ruled out (neurology or imaging, please include if you have done already or we will arrange)
- Diagnosed with chronic daily migraine (>15 headache days per month with >8 days being migraines)
- Patient has failed or is not suitable for 2 oral prophylactic medications
- Patient is amenable to injections and cost of injections ($100 as the injections themselves are not an OHIP covered service)
- **Patient has insurance coverage for onabotulinum toxin A**
  OR
- **Patient may qualify for EAP (under Ontario Drug Benefits – over 65 or on OW or ODSP) as they have completed a 3-month headache diary and have failed 3 prophylactics from 3 different medication classes)**

Dr Holowaty will complete an EAP application if for your patient if they meet criteria, but she relies on the prophylactic medication history you/patient are able to provide to get insurance coverage (page 2).

Name: _____

HCN: _____

DOB: _____

Phone number: _____

Email address: _____

Referring Physician: _____

Billing number: _____

Clinic fax number: _____

Referring Physician Signature: _____

Dr Holowaty has a GP-focused practice in addiction medicine only.

Please fax to the Pharmacy with patient's first prescription

Chronic Migraine Treatment History

Patient Name: _____ Date: _____

Is this patient new to BOTOX® therapy for Chronic Migraine? ☐ Yes ☐ No

Length of time patient afflicted with Chronic Migraine (i.e. # of months or years): _____

Number of headache/migraine days per month: _____ Duration of headaches/migraines: _____ ○ Hours ○ Days

Relevant Diagnostic or Confirmatory Tests Performed

☐ Neurological Consult Date: _____ Comments: _____

☐ MRI / CT Scan Date: _____ Comments: _____

☐ Other (Specify Date and Type): _____

All Prior Relevant Treatments

☐ Non-Opioid Analgesics

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Tricyclic Antidepressants

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Alpha 2 Agonists

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Prednisone

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Methysergide

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Ergots

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Anticonvulsants

☐ Topiramate Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Beta Blockers

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Calcium Channel Blockers

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Opioids

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ Triptans

Drug Name: Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ _____

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ _____

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

☐ _____

Drug Name: _____ Dose: _____ Duration: _____ ☐ Effective ☐ Ltd Benefit ☐ Ineffective ☐ Not Tolerated

Estimated Botox® Dose to be Administered: 155 units

I hereby consent to the collection of the information on this form by the pharmacy as it pertains to my patient to allow them to determine my patient's insurance reimbursement eligibility. I consent to the disclosure of this information, in non-patient identifiable format only, to the manufacturer of BOTOX®, for the purposes of monitoring Canadian third party insurer eligibility criteria, and evaluation.

Physician Signature _____