

Prescription & Enrollment Form  
Botulinum Toxin (Medical Indication)

accredo

Four simple steps to submit your referral.

**1 PATIENT INFORMATION**

Patient's first name \_\_\_\_\_  
 Last name \_\_\_\_\_ Middle initial \_\_\_\_\_  
 Date of birth \_\_\_\_\_  Male  Female Last 4 digits of SSN \_\_\_\_\_  
 Street address \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Parent/guardian (if applicable) \_\_\_\_\_  
 Cell phone \_\_\_\_\_ Other phone \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Patient's primary language:  English  Other If other, please specify \_\_\_\_\_

Please fax copies of front and back of insurance cards with this form.

Insurance company \_\_\_\_\_ Phone \_\_\_\_\_  
 Insured's name \_\_\_\_\_  
 Insured's employer \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
 Identification # \_\_\_\_\_ Policy/group # \_\_\_\_\_  
 Prescription card:  Yes  No If yes, carrier \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Is patient eligible for Medicare?  Yes  No  
 Does patient have a secondary insurance?  Yes  No

**2 PRESCRIBER INFORMATION**

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_  
 Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_  
 Prescriber's title \_\_\_\_\_  
 If NP or PA, under direction of Dr. \_\_\_\_\_  
 Office contact and title \_\_\_\_\_  
 Office contact e-mail \_\_\_\_\_  
 Office/clinic/institution name \_\_\_\_\_  
 Clinic/hospital affiliation \_\_\_\_\_  
 Street address \_\_\_\_\_ Suite # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 NPI # \_\_\_\_\_ License # \_\_\_\_\_  
 Deliver product to:  Office  Clinic  
 Clinic location \_\_\_\_\_

All fields must be completed to expedite prescription fulfillment.

**3 CLINICAL INFORMATION**

PMH: \_\_\_\_\_

Please list indication for botulinum toxin therapy and corresponding ICD-10 code(s):

Note: Diagnosis may be required by payer authorization criteria

Primary ICD-10 code: \_\_\_\_\_

For your convenience, formulations are listed beside their approved indications.

Indication(s):

- Chronic Migraine (Botox®) # of headache days per month \_\_\_\_\_
- Upper limb spasticity (Botox®, Dysport®, Xeomin®)
- Lower limb spasticity (Botox®)
- Cervical Dystonia (Botox®, Dysport®, Xeomin®, Myobloc®)
- Blepharospasm (Botox®, Xeomin®)
- Strabismus (Botox®)
- Urinary Incontinence (Botox®)
- Primary Axillary hyperhidrosis (L74.510)(Botox®)
- Overactive Bladder (Botox®)
- Other \_\_\_\_\_

Date of next injection \_\_\_\_\_ Date of last injection \_\_\_\_\_

NKDA  Known drug allergies \_\_\_\_\_

Concurrent meds \_\_\_\_\_

**4 PRESCRIBING INFORMATION**

Potency units are not interchangeable among botulinum toxin products. Dose and response may differ by product; please see product information.

Medication	Strength/Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Botox®	<input type="checkbox"/> 100 unit vial <input type="checkbox"/> 200 unit vial	To be injected <input type="checkbox"/> IM or <input type="checkbox"/> ID into the _____  (site of administration)	Dispense: _____ # vials  Refills _____  Minimum frequency is 12 weeks unless otherwise specified.
<input type="checkbox"/> Dysport®	<input type="checkbox"/> 300 unit vial <input type="checkbox"/> 500 unit vial	by prescriber, in office for _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Xeomin®	<input type="checkbox"/> 50 unit vial <input type="checkbox"/> 200 unit vial <input type="checkbox"/> 100 unit vial	(condition/indication)	
<input type="checkbox"/> Myobloc®	<input type="checkbox"/> 2,500 units/0.5 mL vial <input type="checkbox"/> 5,000 units/1 mL vial <input type="checkbox"/> 10,000 units/2 mL vial		
<input type="checkbox"/> Prescriber, please check here to authorize ancillary supplies such as needles, syringes, 0.9% Normal Saline, etc. to administer the therapy		As needed for administration	Send quantity sufficient for medication days supply

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

Date \_\_\_\_\_

Substitution allowed \_\_\_\_\_

Date \_\_\_\_\_

Dispense as written \_\_\_\_\_

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

**Please fax completed form to 888.302.1028.** To reach your team, call toll-free 844.412.4764.

**You can now monitor shipments and chat online if you have questions. Go to [MyAccredoPatients.com](http://MyAccredoPatients.com) to log in or get started.**

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