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

All fields must be completed to expedite prescription fulfillment.

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 _____

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
❑ Botox®	❑ 100 unit vial ❑ 200 unit vial	To be injected ❑ IM or ❑ ID into the _____ (site of administration) by prescriber, in office for _____ (condition/indication)	Dispense: _____ # vials _____ Refills Minimum frequency is 12 weeks unless otherwise specified. ❑ Other _____
❑ Dysport®	❑ 300 unit vial ❑ 500 unit vial		
❑ Xeomin®	❑ 50 unit vial ❑ 200 unit vial ❑ 100 unit vial		
❑ Myobloc®	❑ 2,500 units/0.5 mL vial ❑ 5,000 units/1 mL vial ❑ 10,000 units/2 mL vial		
❑ 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 to log in or get started.

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