Prescription & Enrollment Form
Botulinum Toxin (Medical Indication)

accredo®
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Honolulu, HI 96813-5412

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/0.5mL vial ❑ 5,000 units/1mL vial ❑ 10,000 units/2mL 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 Dispense as written Date Substitution allowed

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 808.650.6487. To reach your team, call toll-free 808.650.6488.

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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