Please fax all pages of completed form to your team at 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.

Prescription & Enrollment Form

Botulinum Toxin (Medical Indication)

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

Provider will read the following statement: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber info: Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion location: ☐ Patient's home ☐ Prescriber's office ☐ Infusion site If infusion site, complete information below dotted line:

Infusion info: Infusion site name _____ Clinic/hospital affiliation _____

Site street address _____ Suite # _____

City _____ State _____ Zip _____

Infusion site contact _____ Phone _____ Fax _____ Email _____

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 (REQUIRED): _____ 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®)
- ☐ Cervical Dystonia (Botox®, Dysport®, Xeomin®, Myobloc®)
- ☐ Strabismus (Botox®)
- ☐ Primary Axillary hyperhidrosis (L74.510)(Botox®)
- ☐ Other _____
- ☐ Lower limb spasticity (Botox®)
- ☐ Blepharospasm (Botox®, Xeomin®)
- ☐ Urinary Incontinence (Botox®)
- ☐ Overactive Bladder (Botox®)

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

3 Clinical Information (cont.)

Date of next injection _____ Date of last injection _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
☐ Botox®	☐ 100 unit vial ☐ 200 unit vial	Inject _____ units ☐ IM or ☐ ID into the _____ (site of administration) by prescriber, in office for _____ (diagnosis)	_____ # vials _____ Refills Minimum frequency is 12 weeks unless otherwise specified. ☐ Other
☐ Daxxify®	☐ 100 unit vial		
☐ Dysport®	☐ 300 unit vial ☐ 500 unit vial		
☐ Xeomin®	☐ 50 unit vial ☐ 100 unit vial ☐ 200 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.

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

SIGN HERE _____ _____ _____ _____

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.

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