

Please fax both 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](http://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 \_\_\_\_\_

Male      Female      Last 4 digits of SSN \_\_\_\_\_ Date of birth \_\_\_\_\_

Street address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Parent/guardian (if applicable) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

Alternate caregiver/contact \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ E-mail address \_\_\_\_\_

OK to leave message with alternate caregiver/contact

Patient's primary language:    English    Other    If other, please specify \_\_\_\_\_

## 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/clinic/institution name \_\_\_\_\_

Office address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ NPI # \_\_\_\_\_ License # \_\_\_\_\_

Office contact and title \_\_\_\_\_

Office contact phone number \_\_\_\_\_ Office contact e-mail \_\_\_\_\_

Infusion clinic name \_\_\_\_\_ Office/infusion clinic affiliation \_\_\_\_\_

Street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Deliver product to:    Office    Patient's home    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 (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®)

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 \_\_\_\_\_

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_ Date of birth \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_ Phone \_\_\_\_\_

## 4 Prescribing Information

Medication	Dose	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 _____
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.