Botulinum Toxin Enrollment Form

PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: (_____) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: (_____) - _____ - _____ Fax: (_____) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

3XRX-20-01

CLINICAL CONSIDERATIONS

Diagnosis: _____

ICD10: _____

History of therapies tried/failed (please include dates and reason for discontinuation):

Immunization History
☐ Influenza
Date: _____ /_____ / _____

℞

Medication	Dose/Strength	Directions	Quantity (# of vials)	Refills
☐ **Botox®** (onabotulinumtoxinA)	☐ 100 unit vial ☐ 200 unit vial			
☐ **Dysport®** (abobotulinumtoxinA)	☐ 300 unit vial ☐ 500 unit vial			
☐ **Myobloc®** (rimabotulinumtoxinB)	☐ 2,500 unit/0.5 mL vial ☐ 5,000 unit/1 mL vial ☐ 10,000 unit/2 mL vial			
☐ **Xeomin®** (incobotulinumtoxinA)	☐ 50 unit vial ☐ 100 unit vial ☐ 200 unit vial			

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____
NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

SHIPPING INFORMATION

Ship to: ☒ Physician/Clinic Date Shipment Needed By: ____ /____ / ____