# BOTULINUM TOXIN REFERRAL FORM

AMBER™ SPECIALTY PHARMACY

## PATIENT INFORMATION

| | | |
|---|---|---|
| Last Name | First Name | DOB |
| Gender | Last 4 SSN | Primary Language |
| Address | | |
| City | State | ZIP |
| Email | | |
| Home Phone | Work Phone | Cell Phone |
| Primary Contact Method (check one) | ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ Email ☐ Primary Caregiver ☐ DO NOT CONTACT | |
| Primary Caregiver/Alt Contact Name (If applicable) | | |
| Caregiver/Alt Contact Email | Caregiver/Alt Contact Phone | |

## PRESCRIBER INFORMATION

| | | |
|---|---|---|
| Name of Contact Sending Referral | | Title |
| Preferred Contact Method (check one) ☐ Email ☐ Phone ☐ Fax | Referral Contact Email | |
| Office Phone | Office Fax | |
| Practice / Facility Name | | |
| Address | | |
| City | State | ZIP |
| Prescriber Name / Specialty | | |
| Prescriber State License # | | DEA # |
| NPI # | | Medicaid UPIN # |

## INSURANCE INFORMATION

**Please include a copy of the front and back of insurance card.**

## CLINICAL INFORMATION

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|---|---|---|
| Prescription Type ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment | Therapy Start Date | Last Injection Date |
| Sample/Starter Product Provided? ☐ Yes ☐ No | If yes, Provide Qty | Date Sample Provided |
| If Self-injectable drug, is injection training coordination required by our pharmacy? ☐ Yes ☐ No | Allergies ☐ NKDA ☐ Drug Allergies (please list) | |
| Ship to Address | ☐ Home ☐ Prescriber's Office ☐ Other (please list) | |
| Patient Height (cm/in) | Patient Weight (kg/lbs) | Date Obtained |
| Other/Concomitant Medications | | |
| ICD-10 Code | | |
| Check all that apply ☐ Blepharospasm ☐ Primary Axillary Hyperhidrosis ☐ Spasmodic Torticollis ☐ Spastic Hemiplegia | ☐ Strabismus ☐ Lower Limb Spasticity ☐ Upper Limb Spasticity ☐ Urinary Incontinence ☐ Other:_____ | |

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|---|---|
| ☐ Chronic Migaine Headache | ☐ Yes ☐ No Does the patient display all of the following: 1) Greater than or equal to 15 headache days per month, AND 2) Greater than or equal to 8 migraine days per month, AND 3) Headaches that last 4 hours per day or longer?<br><br>☐ Yes ☐ No Does the patient have a history of failure (after a trial of at least 2 months), contraindication, or intolerance to prophylactic therapy with one agent from two of the following therapeutic classes: 1) Antidepressants 2) Antiepileptics (anti-seizure) 3) Beta Blockers<br><br>☐ Yes ☐ No Will Botox be used in combination with CGRP antagonists [i.e. (Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab)?<br><br>☐ Yes No Will the dose of OnabotulinumtoxinA exceed 155 uniits administered intramuscularly divided over 31 injection sites divided across 7 head and neck muscles every 12 weeks? |
| ☐ Cervical Dystonia | ☐ Yes ☐ No Does the patient have sustained head tilt or abnormal posturing resulting in pain and/or functional impairment?<br><br>☐ Yes ☐ No Does the patient have recurrent involuntary contraction of one or more muscles of the neck (e.g. sternocleidomastoid, splenius, trapezius, posterior cervical)? |
| ☐ Overactive Bladder | ☐ Yes ☐ No Does the patient have urinary incontinence, urgency, or frequency?<br><br>☐ Yes ☐ No Does the patient have a history of failure, contraindication, or intolerance to two anticholinergic medications (Ex.Darifenacin, fesoterodine, oxybutynin, solifenacin, tolterodine, trospium)?<br><br>☐ Yes ☐ No Will the dose of OnabotulinumtoxinA exceed 100 units divided over 20 injection sites every 12 weeks? |

**We accept Escribe and fax prescriptions.**

**P** 855.896.9254 | **F** 877.645.7514 | 10004 S. 152nd St, Suite A, Omaha NE 68138

REV.0421

# PRESCRIPTIONS

## MAIN INFORMATION (MUST BE FILLED OUT TO PROCESS PAGES TOGETHER FOR OFFICIAL PATIENT RECORDS)

| Patient Last Name | Patient First Name | DOB |
|---|---|---|
| Address | | |
| City | State | ZIP |
| Date of Issue | | |

| Practice / Facility Name | | |
|---|---|---|
| Practice Address | | |
| City | State | ZIP |
| NPI # | DEA # | |

## PRESCRIPTION INFORMATION

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitutions. This form is not a valid prescription form for writing controlled medications.

| MEDICATION | DOSE | DIRECTIONS | QTY | REFILLS | DAW (Dispense as Written) |
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**Total RXs** _____

_____ _____ /_____ /_____

Prescriber Signature Date

_____ _____ /_____ /_____

Supervising Physician Signature (where required by state law) Date

***The information contained in this document will become a legal prescription.* ***Follow all state Medical Board guidelines when completing, inclusive of guidelines that pertain to the number of prescriptions allowed on a single prescription form.*** *If more than one page is required, make additional copies. Use state board mandated language for dispensing brand name medications or generic substitution and follow physician signature requirements.*