BOTULINUM TOXIN REFERRAL FORM

PHONE 888.370.1724 | **FAX** 877.645.7514

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐ M ☐ F	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)	Alt Contact Email	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	Prescriber Name / Specialty		
Address	City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #

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

CLINICAL INFORMATION - Please include applicable clinical chart notes

Patient New to Therapy ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment | Therapy Start Date

Other/Concomitant Medications (please list)

Allergies ☐ NKDA ☐ Drug Allergies (please list)

Patient Height (cm/in) | Weight (kg/lbs) | Date Obtained

☐ 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?

☐ 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

☐ Yes ☐ No Will Botox be used in combination with CGRP antagonists [i.e. (Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab)?

☐ Yes ☐ No Will the dose of OnabotulinumtoxinA exceed 155 units 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?

☐ 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?

☐ Yes ☐ No Does the patient have a history of failure, contraindication, or intolerance to two anticholinergic medications (Ex.Darifenacin, fesoterodine, oxybutynin, solifenacin, tolterodine, trospium)?

☐ Yes ☐ No Will the dose of OnabotulinumtoxinA exceed 100 units divided over 20 injection sites every 12 weeks?

Ship to Address ☐ Home ☐ Prescriber's Office ☐ Other (please list)

Check all that apply
☐ Blepharospasm ☐ Spasmodic Torticollis ☐ Strabismus ☐ Upper Limb Spasticity ☐ Other:____________
☐ Primary Axillary Hyperhidrosis ☐ Spastic Hemiplegia ☐ Lower Limb Spasticity ☐ Urinary Incontinence

ICD-10 Code ☐ Code __________ Description ______________________________

PRESCRIPTION INFORMATION - Please Escribe if required by state law

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
☐ Botox®	☐ 50 unit vial ☐ 100 unit vial ☐ 200 unit vial	To be injected ☐ IM or ☐ ID into the: ______________________________ (site of administration)		
☐ Dysport®	☐ 300 unit vial ☐ 500 unit vial	by prescriber, in office for:		
☐ Myobloc®	☐ 2,500 unit vial ☐ 5,000 unit vial ☐ 10,000 unit vial	______________________________ (condition/indication)		
☐ Xeomin®	☐ 50 unit vial ☐ 100 unit vial ☐ 200 unit vial	Minimum frequency is 12 weeks unless otherwise specified.		

If shipped to Prescriber's office, Physician accepts on behalf of patient for office administration.

______________________ Prescriber Signature | ________ Date | ______________________ Supervising Physician Signature (where required by state law) | ________ Date

______________________ DAW (Dispense as Written) | ________ Date | ______________________ Brand Necessary (must handwrite)

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with his/her state specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state specific requirements could result in outreach to the prescriber.*

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REV.0122

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