BOTULINUM TOXIN REFERRAL FORM

Amber PHARMACY
Phone: (855) 896.9254 Fax: (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone		
SSN	Allergies	
Sex ❑ Male ❑ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax	Email	

Prescriber Specialty: ☐ Neurologist ☐ Dermatologist ☐ Ophthalmologist ☐ Urologist ☐ Other:

Diagnosis/Clinical Information

Allergies: _____ Concurrent Medications: _____

ICD-10 Code: _____

☐ Blepharospasm	☐ Primary Axillary Hyperhidrosis	☐ Lower Limb Spasticity
☐ Cervical Dystonia	☐ Spasmodic Torticollis	☐ Upper Limb Spasticity
☐ Chronic Migraine	☐ Spastic Hemiplegia	☐ Urinary Incontinence
☐ Overactive Bladder	☐ Strabismus	☐ Other: _____

Prescription type: ☐ Naive/New Start ☐ Restart ☐ Continued Treatment ☐ Last Injection Date: / /

Prescription Information

MEDICATION	# OF VIALS	DIRECTIONS FOR USE (INCLUDE FREQUENCY, MINIMUM IS 12 WEEKS, UNLESS OTHERWISE SPECIFIED)	LOCATION FOR INJECTION (SPECIFY SITE(S) AND NUMBER OF UNITS PER SITE)	REFILLS
Botox® ☐ 100 unit vial ☐ 200 unit vial				
Dysport® ☐ 300 unit vial ☐ 500 unit vial				
Myobloc® ☐ 2,500 units/0.5 mL vial ☐ 5,000 units/1 mL vial ☐ 10,000 units/2 mL vial				
Xeomin® ☐ 50 unit vial ☐ 100 unit vial ☐ 200 unit vial				

Date needed: _____/_____/_____ Medication delivery to (choose one): ☐ Prescriber: ☐ Other:

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 substitution: _____

PRESCRIBER MUST MANUALLY SIGN - STAMP SIGNATURE, SIGNATURE BY OTHER PERSONNEL AND COMPUTER-GENERATED SIGNATURES WILL NOT BE ACCEPTED

_____ _____

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (Date) DISPENSE AS WRITTEN/Do Not Substitute (Date)