



BOTULINUM TOXIN REFERRAL FORM

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)			Prescriber Information		
Last Name	First Name	DOB				Practice/Facility Name		
Address						Address		
City	State	ZIP				City	State	ZIP
Phone						Prescriber Name		
SSN		Allergies				Prescriber NPI		
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	Weight (kg)	Height (ft.in)		Nurse/Key Contact			Phone/Pager
Insurance Plan		Plan ID #		Fax			Email	

Prescriber Specialty: Neurologist Dermatologist Ophthalmologist Urologist Other:

Diagnosis/Clinical Information

Allergies: _____ Concurrent Medications: _____
 ICD-10 Code: _____

<input type="checkbox"/> Blepharospasm	<input type="checkbox"/> Primary Axillary Hyperhidrosis	<input type="checkbox"/> Lower Limb Spasticity
<input type="checkbox"/> Cervical Dystonia	<input type="checkbox"/> Spasmodic Torticollis	<input type="checkbox"/> Upper Limb Spasticity
<input type="checkbox"/> Chronic Migraine	<input type="checkbox"/> Spastic Hemiplegia	<input type="checkbox"/> Urinary Incontinence
<input type="checkbox"/> Overactive Bladder	<input type="checkbox"/> Strabismus	<input type="checkbox"/> 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® <input type="checkbox"/> 100 unit vial <input type="checkbox"/> 200 unit vial				
Dysport® <input type="checkbox"/> 300 unit vial <input type="checkbox"/> 500 unit vial				
Myobloc® <input type="checkbox"/> 2,500 units/0.5 mL vial <input type="checkbox"/> 5,000 units/1 mL vial <input type="checkbox"/> 10,000 units/2 mL vial				
Xeomin® <input type="checkbox"/> 50 unit vial <input type="checkbox"/> 100 unit vial <input type="checkbox"/> 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)

I authorize Amber Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

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