



# 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
SSN			Prescriber Name		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Weight (kg)	Height (ft.in)	Prescriber NPI		
Emergency Contact		Phone	Nurse/Key Contact		Phone/Pager
Insurance Plan		Plan ID #	Fax		

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
<b>Botox®</b> <input type="checkbox"/> 100 unit vial <input type="checkbox"/> 200 unit vial				
<b>Dysport®</b> <input type="checkbox"/> 300 unit vial <input type="checkbox"/> 500 unit vial				
<b>Myobloc®</b> <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				
<b>Xeomin®</b> <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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