Botox Enrollment Form

VALUE SPECIALTY PHARMACY

Patient Data

Patient Name: _____ Birthdate: _____
Sex: ❑ Male ❑ Female Height: _____ Weight: _____ lbs kg
SSN #: XXX-XX-_____
Known Allergies: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Primary Language: _____
Alternate Caregiver Name/Phone: _____
Patient Email: _____

Ins. Data

Primary Insurance: _____
Secondary Insurance: _____
Policy: _____ Group#: _____
Policy: _____ Group#: _____

❑ ***Patient has commercial insurance and authorizes pharmacy to apply for manufacturer copay card. Email must be provided above.***

Diagnosis

Primary Diagnosis: _____ ICD 10: _____
Secondary Diagnosis: _____ ICD 10: _____

Clinical Information

Please attach clinical notes to expedite the prior authorization.

Chronic spasticity
- ❑ Has spasticity that interferes with daily activities
- ❑ Has spasticity that is expected to result in joint contracture with future growth
- ❑ If patient has contractures, surgical intervention has been considered
- ❑ Has tried and failed or has contraindication or inttolerance to an oral medication used to treat spasticity
- ❑ Medication is being prescribed to enhance function or allow for additional therapeutic modalities to be used
- ❑ Will use the medication in conjuction with other appropraite modalities

Axillary hyperhidrosis
- ❑ Has tried and failed or has contraindication or intolerance to a topical agent such as aluminum chloride 20% solution

Chronic migraine
- ❑ Migraine headache is not attributable to other causes, such as medication overuse
- ❑ Has tried and failed or has contraindication or intolerance to medications in other drug classes that are used for migraine prevention:
  - ❑ Anticonvulsants (i.e., divalproex, topiramate, valproic acid)
  - ❑ Antidepressants (i.e., amitriptyline, venlafaxine)
  - ❑ Beta blockers (i.e., metoprolol, propranolol, timolol)

Urinary incontinence due to detrusor overactivity
- ❑ Has associated neurologic condition
- ❑ Has tried and failed or has a contraindication or an intolerance to an anticholinergic medication used for treatment of urinary incontinence

Overactive bladder
- ❑ Has symptoms of urge uniary incontinence, urgency, and frequency
- ❑ Has tried and failed or has a contraindications or an intolerance to at least 2 medications for treatment of overactive bladder (i.e., anticholinergics, beta-3 adrenergic agonists)

Prescription

Medication	Strength	Directions	Quantity	Refills
Botox®	❑ 100 unit vial ❑ 200 unit vial	Inject _____ units ❑ intramuscularly ❑ intradermally every _____ weeks in physician office	Quantity sufficient for 1 administration	

Is patient new to this therapy: ❑ YES ❑ NO | **Scheduled injection date:** _____/_____/_____

Prescriber Data

Prescribers Name: _____
DEA#: _____ NPI: _____
Practice Name: _____
Contact: _____
Address: _____
Phone: _____ Fax: _____
City: _____ State: _____ Zip: _____
Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Value Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____

This prescription will be filled generically unless prescriber writes **"DAW"** in the box to the right.