UnityPoint at Home

SPECIALTY PHARMACY
Phone: 1 (877) 804-2713
Fax: 1 (855) 806-7285

BOTULINUM TOXIN REFERRAL (NON-MIGRAINE MEDICAL INDICATION)

PATIENT INFORMATION

Please fax a copy of ALL of patient's Prescription, Primary and Secondary insurance cards (both sides)
Also please include any other beneficial information for prior authorization and dispensing assessments.

Patient Name ____________________ **DOB** __________ ☐ Male ☐ Female

Address ____________________ **City** __________ **State** __________ **Zip** __________

Home Phone __________ **Cell Phone** __________ **Work phone** __________ **Email** __________

Primary Language ☐ English ☐ Spanish ☐ Other: specify __________ **Allergies** __________

RX Member ID __________ **RX Group ID** __________ **RX PCN** __________ **RX BIN** __________

DIAGNOSIS (USE THE MOST APPROPRIATE CODE)

☐ G24.5 Blepharospam (Botox®, Xeomin®)	☐ G24.3 Cervical Dystonia (Botox®, Dysport®, Myobloc®, Xeomin®)
☐ N32.81 Overactive Bladder (Botox®)	☐ L74.510 Primary Axillary hyperhidrosis (Botox®)
☐ H50.9 Unspecified Strabismus (Botox®)	☐ Lower Limb Spasticity (Botox®)
☐ Upper Limb Spasticity (Botox®, Dysport®, Xeomin®)	
☐ Other:	

CLINICAL INFORMATION / PATIENT HISTORY

DATE WHEN THE SYMPTOMS BEGAN (MM/DD/YYYY): __________

PLEASE SUBMIT SUPPORTING DOCUMENTATION

Height:	Weight:	Date of Next injection: __/__/__	Date of last injection (if applicable): __/__/__

History of recurrent clonic or tonic involuntary contractions of one or more of the following muscles: Sternocleifomastoid, trapezius, levator scapulae, scalene or posterior cervical muscles (e.g., splenius, semispinalis and longissimus) ☐ No ☐ Yes

Increased muscle tone:
☐ Upper limbs (elbow flexors, wrist flexors, finger flexors and/ or thumb) and is impacting the patient in this manner :
☐ Lower (gastrocnemius, soleus, tibialis posterior, flexor halluces longus and/or flexor digitorum longus) and is impacting the patient in this manner :

Sustained head tilt or abnormal posturing with limited range of motion in the neck? ☐ No ☐ Yes

Neck Pain ☐ No ☐ Yes If yes, Intensity: ☐ Mild ☐ Moderate ☐ Severe

Current Medication List:

Other relevant details:

PRESCRIPTION HISTORY

PATIENT HAS TRIED AND FAILED THE BELOW MEDICATIONS

Medication:	Duration:	Class:	Outcome:
Medication:	Duration:	Class:	Outcome:
Medication:	Duration:	Class:	Outcome:
Medication:	Duration:	Class:	Outcome:

Other:

PRESCRIPTION

DATE NEEDED: / / ☐ **NEW PRESCRIPTION** ☐ **REFILL PRESCRIPTION** ☐ **NEW TO THERAPY**

Note: Potency units are not interchangeable among botulinum toxin products. Dose and response may differ by product; please see product information.

☐ **Botox®** (OnabotulinumtoxinA) – ☐ 100 unit vial ☐ 200 unit vial
Inject ____units IM to ____________________ every __________ refills __________

☐ **Dysport®** (AbobotulinumtoxinA) – ☐ 300 unit vial ☐ 500 unit vial
Inject ____units IM to ____________________ every __________ refills __________

☐ **Myobloc®** (RimabotulinumtoxinB) – ☐ 2500 unit / 0.5 mL vial ☐ 5000 unit / 1 mL vial ☐ 10,000 unit / 1.5 mL vial
Inject ____units IM to ____________________ every __________ refills __________

☐ **Xeomin®** (IncobotulinumtoxinA) – ☐ 50 unit vial ☐ 100 unit vial
Inject ____units IM to ____________________ every __________ refills __________

Medication to be given by Provider in office. Any unused portion to be discarded.

☐ Dispense all supplies needed to administer medication as needed for administration. Send quantity sufficient for medication day supply.
☐ No supplies needed

☐ **Other / Additional Instructions** (as needed):

BY SIGNING BELOW, I CERTIFY THAT THE ABOVE THERAPY IS MEDICALLY NECESSARY.

Prescriber's Signature: (No Stamps)		**DATE:**	

Print Prescriber's Name: ____________________ NPI: __________ Phone __________

Address ____________________ City __________ State __________ Fax __________