

Prescription & Enrollment Form Botox & Myobloc

(800) 962-6339 Office
(866) 755-6339 Fax



Patient Information

| | |
|--------------------|---------------------|
| _____ | _____ |
| Last Name | First Name |
| _____ | _____ |
| Social Security # | Date of Birth |
| _____ | _____ |
| Parent or Guardian | |
| _____ | _____ |
| Home Phone | Other Contact Phone |
| _____ | _____ |
| Home Address | |
| _____ | |
| City, State, Zip | |

Insured Information

| | |
|---|-------------------------|
| _____ | |
| Primary Insurance (Fax copy of card – both sides) | |
| _____ | |
| Subscribers Name | Relationship to Patient |
| _____ | _____ |
| Policy # | Group # |
| _____ | _____ |
| Primary Insurance Phone | |
| _____ | |
| Prescription Card (Fax copy of card – both sides) | |
| _____ | |
| Carrier | Policy # |

| DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnoses) | |
|--|-----------------------------------|
| Primary Diagnosis | Secondary Diagnosis |
| Allergies: | |
| Height _____ Weight _____ | What Medications have been tried? |

| | |
|--|--|
| <input type="checkbox"/> Benign essential blepharospasm | <input type="checkbox"/> Spasmodic dystonia |
| <input type="checkbox"/> Cervical Dystonia | <input type="checkbox"/> Spastic Torticollis |
| <input type="checkbox"/> Cranial nerve damage (hemifacial spasms) in patients 12 yrs. or older | <input type="checkbox"/> Strabismus and/or blepharospasm associated with dystonia |
| <input type="checkbox"/> Dynamic muscle contracture in pediatric Cerebral Palsy patients | <input type="checkbox"/> Sykinetic closure of the eyelid associated with cranial nerve aberrant regeneration |
| <input type="checkbox"/> Oromandibular dystonia | <input type="checkbox"/> Treatment of muscle spasticity resulting from CNS disorder or CNS injury |
| <input type="checkbox"/> Other | |

| PRESCRIPTION INFORMATION | | | | |
|------------------------------------|------|-----------|----------|---------|
| Medication | Dose | Frequency | Quantity | Refills |
| <input type="checkbox"/> Botox ® | | | | |
| <input type="checkbox"/> Myobloc ® | | | | |

| DELIVERY INSTRUCTIONS | | |
|--|---------------------------------------|------------------------|
| <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other | Address _____ City/State/Zip _____ | Date Medication Needed |

| | |
|---------------------------------|------------------|
| Physician's Name (Please Print) | Physician's DEA# |
| Physician's Address | |
| Phone | Fax |
| Physician's Signature | Date |
| License # | NPI # |
| Dr.'s Office Contact Name | Contact Phone # |

Fax completed form to Medex BioCare (866) 755-6339