LifeCare
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BOTULINUM TOXIN (MEDICAL INDICATION)

Patient Information

Patient's Name (Last, First, Middle) _____ Sex_____

DOB _____ Phone_____ Weight in lbs:_____ in kgs._____

Known Allergies_____ Height_____ Alternate Care Giver_____

Diagnosis Please provide the most specific ICD-10 Code_____

- ☐ Chronic Migraine (Botox®) #of headache days per month_____
- ☐ Upper limb spasticity (Botox®,Dysport®, Xeomin®)
- ☐ Lower limb spasticity (Botox®)
- ☐ Cervical Dystonia (Botox®, Dysport®, Xeomin®, Myobloc®)
- ☐ Blepharospasm (Botox®, Xeomin®)
- ☐ Strabismus (Botox®)
- ☐ Urinary Incontinence(Botox®)
- ☐ Primary Axillary hyperhidrosis (L74.510) (Botox®)
- ☐ Overactive Bladder (Botox®)
- ☐ Other_____ Date of next Injection_____Date of last injection_____
- ☐ NKDA(Drug Allergies)_____
- ☐ Concurrent Meds_____

Medication	Directions	Quantity & Refills
☐ **Botox®** ☐ 100 unit vial ☐ 200 unit vial	☐ **To be injected IM** ☐ **To be injected ID** ☐ **By Prescriber in office** **For _____** **Condition/Indication** _____ **As needed for admin** _____	**_____# of vials** **_____ Refills** **Minimum frequency is 12 weeks unless otherwise specified.** ☐ **Other_____** **Send quantity sufficient for medication days supply._____**
☐ **Dysport®** ☐ **300 unit vial** ☐ **500 unit vial**		
☐ **Xeomin®** ☐ 50 unit vial ☐ 100 unit vial ☐ 200 unit vial		
☐ **Myobloc** ☐ 2,500 units/0.5 mL vial ☐ 5,000 units/1mL vial ☐ 10,000 units/2mL vial		
☐ **Prescriber please check here to authorize ancillary supplies, such as needles, syringes, 0.9% saline to administer therapy**		

- Please include recent clinical notes, labs, tests, with the prescription to expedite the prior authorization

****ORDERING PROVIDER**

Dispense as written:_____Date:_____

Provider's Name:_____ Phone:_____ Fax:_____

Physicians NPI:_____