

PATIENT INFORMATION

Last Name	First Name	MI	Gender <input type="checkbox"/> M <input type="checkbox"/> F	ID Number
Home Address			City	State
			Zip	Date of Birth
Parent or Guardian Name				Home Phone Number ()
Shipping Address(if different from home address)			<input type="checkbox"/> Ship to MD	Work Phone Number ()

INSURANCE INFORMATION (fill out entirely or fax a copy of patient's Insurance card, both sides)

Primary Insurance	Secondary Insurance
Insured	Insured
Policy Number	Policy Number
Group Number	Group Number
Phone Number	Phone Number

PRIMARY DIAGNOSIS

	530.0	Achalasia		343.0	Muscle Spasm with Cerebral Palsy
	333.81	Blepharospasm		378.0	Strabismus
	952.0	Cervical Dystonia			Torsion Dystonia
	351.0	Facial Nerve (VII) Disorders			Torticollis
	705.21/22	Hyperhidrosis			Other Specify:

REASON FOR PRIOR AUTHORIZATION REQUEST:

If patient's primary diagnosis was hyperhidrosis (705.21 or 705.22), did the patient try and fail a minimum 30-day course of therapy with Drysol or Xerac? Y N

List previous medications tried with length of therapy for each and adverse reactions/intolerances associated with the agent.

PRESCRIPTION INFORMATION

Botox _____ Estimated Length of Therapy	Myobloc _____ Estimated Length of Therapy
Directions:	Directions:
Qty _____ Refill x _____ doses	Qty _____ Refill x _____ doses

PRESCRIBER INFORMATION

Prescriber	Specialty	Office Contact	Phone Number
Address		City	State
		Zip	Fax Number
Today's Date	Date Needed	I certify that the above therapy is medically necessary and all the above information is accurate to the best of my knowledge.	
		Physician's Signature:	
		NPI _____	
		DEA _____	

Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Saturday delivery requires approval from an Ascend pharmacist.

For refills, please call-in or fax 7 days in advance of next appointment.

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