



**Botox (Botulinum toxin type A injection)
Myobloc (Botulinum toxin type B injection)**

Member Information

Name _____
Enrollment / Cardholder ID _____
Group / Plan _____
Birth Date _____
Address _____
City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent
Gender (Circle)
Male Female
AGE: _____

Practitioner Information

Name _____
Agent / Contact Name _____
Specialty _____
Office / Clinic Name _____
Address _____
City State Zip _____
Phone () - _____
Fax () - _____
Email _____ @ _____

**Primary Diagnosis Condition /
Diagnosis Related – Reason for Request:**

- Cervical dystonia with severe abnormal head position and neck pain associated with CD.
- Strabismus and blepharospasm associated with dystonia (including benign essential blepharospasm or VII nerve disorders)
- Other? Please define: _____

Strength / Dose

Duration of Therapy (Expected)

**Formulary Alternatives
Attempted/Outcome**

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? Y N

Pharmacy Phone Number

Practitioner Signature

Date Received: _____
Reviewed By: _____
Forwarded To: _____

**FAX Form to
877-800-5633**