aleracare
advanced specialty pharmacy

Neuromuscular Disorders
Referral Form

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height: Weight:	Allergies:		Phone:	Fax:
Emergency Contant:	Phone:		Contact Person:	

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No

Does the patient need interpreter services: ◯ Yes ◯ No

Documentation (Required)

◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Specific Labs Needed (note: send ALL labs, must include specific labs listed here)

◯ Other: _____

Client Consideration

Diagnosis (ICD 10):

◯ G24.3 Spasmodic torticollis
◯ G24.5 Blepharospasm
◯ G51.0 Bell's palsy
◯ G80.1 Spastic diplegic cerebral palsy
◯ H50.9 Unspecified strabismus
◯ K22.0 Achalasia of cardia
◯ L74.510 Primary focal hyperhidrosis, axilla
◯ L74.511 Primary focal hyperhidrosis, face
◯ L74.512 Primary focal hyperhidrosis, palms
◯ L74.513 Primary focal hyperhidrosis, soles
◯ L74.519 Primary focal hyperhidrosis, unspecified
◯ L74.52 Secondary focal hyperhidrosis
◯ S14.101A Unspecified injury at C1 level of cervical spinal cord, initial encounter
◯ S14.102A Unspecified injury at C2 level of cervical spinal cord, initial encounter
◯ S14.103A Unspecified injury at C3 level of cervical spinal cord, initial encounter
◯ S14.104A Unspecified injury at C4 level of cervical spinal cord, initial encounter
◯ Other (please specify): _____

Medication	Dose	Directions for Use	Qty	Refills
◯ **BOTOX®** (Onabotulinumtoxin A)	◯ 100 Unit Vial ◯ 200 Unit Vial			
◯ **DYSPORT®** (Abobotulinumtoxin A)	◯ 300 Unit Vial ◯ 500 Unit Vial			
◯ **MYBOLOC®** (Rimabotulinumtoxin B)	◯ 2,500 Unit Vial ◯ 5,000 Unit Vial ◯ 10,000 Unit Vial			

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

Prescriber's Signature **Date**