AccessLink
a BioScript Solutions system

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AccessLink Botox Prescription Form

Patient Information

Name: _____ **DOB** (DD/MM/YYYY): ____/_____/_____ **PHN:**_____

Address: _____ **Allergies:** _____

Home #: _____ **Cell #:** _____ **Email:** _____

Insurance Name:_____ **Group ID:**_____ **Certificate ID**: _____

Patient to be initially contacted via: ☐ call ☐ email **Best time to reach patient:** ☐ morning ☐ afternoon ☐ evening

☐ Patient has consented to AccessLink receiving and using the information on this form and AccessLink contacting the patient

☐ Verbal Consent Received by: _____ Date of consent: _____

Prescription

BOTOX THERAPEUTIC (Botulinum Toxin type A)

For Injection at an interval as directed by the physician

Quantity: _____ (50 units per vial)

_____ (100 units per vial)

_____ (200 units per vial)

Repeats: _____

Indication: ☐ Chronic Migraine

☐ Patient experiences over 15 headache days/month lasting longer than 4 hours/day.

☐ Other: _____

List or attach any previously tried medications (dose, duration, outcome):

Shipping Information

Deliver to office:

☐ Next Appointment Date:_____

Prescriber Info and Authorization

Clinic Contact: _____ **Address:** _____

Phone: _____ **Fax:** _____ **Email:** _____

Prescriber Name: _____ **License #:** _____

Prescriber Signature: _____ **Date:** _____

Prescriber Certification.
This prescription represents the original of the prescription drug order.
The pharmacy address noted above is the only intended recipient and there are no others.
The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.