

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ Please fax a copy of front and back of the insurance card(s).	Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: <input type="checkbox"/> _____ <input type="checkbox"/> _____ ICD-10		Diagnosis Date: _____	
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No _____ _____ _____	Reason for Discontinuation of Therapy _____ _____ _____	Approximate Start Date _____ _____ _____	Approximate End Date _____ _____ _____
Comorbidities: _____ Concomitant Medications: _____ Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			

Prescription	Directions	Quantity	Refill
<input type="checkbox"/> Botox [®] <input type="checkbox"/> 100 Unit Vial <input type="checkbox"/> 200 Unit Vial	Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____
<input type="checkbox"/> Dysport [®] <input type="checkbox"/> 300 Unit Vial <input type="checkbox"/> 500 Unit Vial	Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____
<input type="checkbox"/> Myobloc [®] <input type="checkbox"/> 2500 Unit Vial <input type="checkbox"/> 5000 Unit Vial <input type="checkbox"/> 10000 Unit Vial	Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____
<input type="checkbox"/> Xeomin [®] <input type="checkbox"/> 50 Unit Vial <input type="checkbox"/> 100 Unit Vial <input type="checkbox"/> 200 Unit Vial	Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____

Ship to: Patient Physican Office CoxHealth at Home Needs by date: _____

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home, and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to CoxHealth at Home.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 855-419-4663 to obtain instructions as to the proper destruction of the transmitted material. Thank you.