AccessLink
a BioScript Solutions system

Tel: 1-888-398-0028 | Fax: 1-855-278-5182
Email: accesslink@bioscript.ca

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's receipt, use and disclosure of their personal information for the purpose of i) drug reimbursement ii) pharmacy and iii) clinical services.

☐ 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: ☐ Blepharospasm ☐ Hemifacial Spasm
☐ 7th Nerve Disorder ☐ Strabismus
☐ Cervical Dystonia/Spasmodic Torticollis
☐ Equinus Foot (**Due to cerebral palsy:** ☐ **Yes** ☐ **No)**
☐ Achalasia
☐ Focal Spasticity **(Due to stroke:** ☐ **Yes** ☐ **No)**
☐ 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. Prescriber agrees that AccessLink may use and disclose their information for the purposes of administering this program. AccessLink may modify or terminate this program at any time. The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.