

Physician Request Form Myobloc® or Botox®

Fax to Keystone Mercy Pharmacy Services at **215-937-5018**, or to speak to a representative call **800-588-6767**. Form must be completed for processing.

Patient Name: _____

Keystone Mercy ID#: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Phone #: _____ Height: _____ Weight: _____ lbs = _____ Kg

Birth Date: _____

Physician Name: _____

License #: _____

Address: _____

Apt # or Suite #: _____

City: _____ State: _____

Zip Code: _____

Contact Person: _____ Phone #: _____

Fax #: _____

Physician Signature: _____

Date: _____

To be Administered from: _____ to _____ or on: _____

Diagnosis: _____

ICD-9 Diagnosis Code: _____

Select Botulinum Toxin: Botox (Botulinum A) Myobloc (Botulinum B) Total Dose: _____

Sig (How Administered): _____

Please indicate dosage administered at each site or attach documentation of doses and sites injected.

| <u>Injection Site</u> | <u>Approximate Dose</u> |
|-----------------------|-------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Comments or additional information:

Note: Delivered by Keystone Mercy Specialty Pharmacy Provider Only. Delivered Directly to the Physician's Office

Deliver to Physician's Office Other _____

All information requested on this form must be complete. Missing information may result in denial or unnecessary delays in authorization.