ivira specialty pharmacy

Neuromuscular Block Referral Form

Please fax completed referral form to ivira:
(302) 499-8729
Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME: | PREFERRED CONTACT #:

DATE OF REFERRAL: | GENDER: ☐ F ☐ M

SOCIAL SECURITY NUMBER: | ADDRESS:

DATE OF BIRTH: GENDER: ☐ F ☐ M | CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ G24.3 - Spasmodic torticollis
☐ G24.5 - Blepharospasm
☐ 780.8 - Hyperhidrosis
☐ G24.8 - Dystonia
☐ G81.11 - Spasmodic Hemiplegia affecting right dominant side
☐ Other: _____
☐ G43.719 - Chronic migraine
☐ G81.12 - Spasmodic Hemiplegia affecting left dominant side

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. PATIENT DEMOGRAPHICS ☐ 3. MOST RECECNT LABS ☐ 4. H & P

MEDICATION SELECTION:

BOTOX® onabotulinumtoxinA injection

STRENGTH: ☐ 100 UNIT VIAL ☐ 200 UNIT VIAL

SIG: ☐ INJECT _____ UNITS IM EVERY _____ ☐ WEEKS or ☐ MONTHS REFILLS:_____
(To be given by MD in office, any unused portion to be discarded)

Dysport® (abobotulinumtoxinA)

STRENGTH: ☐ 300 UNIT VIAL ☐ 500 UNIT VIAL

SIG: ☐ INJECT _____ UNITS IM EVERY _____ ☐ WEEKS or ☐ MONTHS REFILLS:_____
(To be given by MD in office, any unused portion to be discarded)

MYOBLOC® rimabotulinumtoxinB Injection [5,000 Units/mL]

STRENGTH: ☐ 2,500 UNIT VIAL ☐ 5,000 UNIT VIAL ☐ 10,000 UNIT VIAL

SIG: ☐ INJECT _____ UNITS IM EVERY _____ ☐ WEEKS or ☐ MONTHS REFILLS:_____
(To be given by MD in office, any unused portion to be discarded)

XEOMIN® incobotulinumtoxinA

STRENGTH: ☐ 100 UNIT VIAL

SIG: ☐ INJECT _____ UNITS IM EVERY _____ ☐ WEEKS or ☐ MONTHS REFILLS:_____
(To be given by MD in office, any unused portion to be discarded)

DATE SHIPMENT NEEDED: _____

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

I hereby authorize Ivira to contact my prescribing provider to coordinate the delivery, receipt and storage of my prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. Signature serves as the Patient Ship Authorization.

▶▶▶▶▶▶▶▶ _____
PATIENT SIGNATURE:

PRESCRIBER INFORMATION:

PHYSICIAN NAME: | PHONE:

OFFICE CONTACT: | FAX:

ADDRESS: | LICENSE #:

CITY, STATE, ZIP: | NPI:

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PHYSICIAN SIGNATURE: DATE: