Botox Prescription Form **Fax to BioScript Pharmacy at: 1-877-512-4679**

Physician Section

☐**Dr. Nneka Pamela Odiegwu** ☐**Dr. Folake Pepple** ☐**INJECTED**

Vanguard Medical Clinic
#111, 2066 18th Avenue NE ☐**VERIFY COVERAGE**
Calgary, Alberta, T2E 8N5
Phone: (403)250-9509 Fax: (403)250-5879 ☐**COPAY CARD**

Dose: ☐ Botox 50 units ☐Botox 100 units ☐Botox 200 units

Indication: ☐ Chronic Migraine as per PREEMP protocol ☐ Hyperhidrosis ☐ Other:

☐ Inject every 12 weeks for 18 months Additional Directives: _____

Date: _____ MD Signature*: _____

*I certify that I have counseled the patient on the appropriate use of BOTOX® and the details relevant to his/her particular indication.

Patient Section (MUST BE COMPLETED IN FULL FOR PROCESSING)

Name: _____ DOB(MM/DD/YYYY): _____
Mailing Address: _____
_____
Home Phone: _____ Cell: _____ Work: _____
Preferred Method of contact _____ Email Address (for insurance forms): _____
Alberta Health Card Number: _____-_____
Allergies: _____

Patient Section 2 - - Insurance Information Please fill out on your first visit

Primary Plan Information:
Insurance Company: _____ Plan/Contract/Group# _____
Certificate/ Member ID# _____ Section (only for Blue Cross) _____
Primary Cardholder's Name: _____ Cardholder DOB(MM/DD/YYYY) _____
Cardholder's relationship to you; _____
AISH File # X_____ Adult Health Benefits File # _____
☐ Alberta Blue Cross Non-Group Coverage (or Group 1) ☐ Alberta Blue Cross Seniors Coverage
Secondary Plan Information: Insurance Company: _____Plan/Contract/Group# _____
Certificate/ Member ID# _____Cardholder Name: _____

Patient Consent: *By signing this form, I am consenting to allow the above physician to share my health and insurance information as necessary with a pharmacy to allow them to determine my coverage and/or bill my insurance company/provincial drug plan. I further consent to having the above physician act as my agent and to allow the above physician to obtain BOTOX® on my behalf from Allergan Inc. I will provide my credit card information to the pharmacy, if required, to allow them to bill my card for any co-pay or deductible required by my insurer for the BOTOX® medication. By signing this form, I am consenting to allow the pharmacy to access my provincial Netcare file to review medication information as required to complete any insurance forms to obtain coverage for my Botox® treatments.*

X_____
(Must be signed by Patient)

Patient Section 3- - Payment Information (REQUIRED for Provision to Pharmacy)

Credit Card Type: ☐VISA ☐MasterCard ☐American Express ☐VISA Debit
Number on Card: _____ Expiry Date (MM/YY): ____/ _____

Name on Card: _____ Relationship of Cardholder to you: _____