BOTOX® ACCESS PROGRAM | FOR HYPERHIDROSIS

BAP Prescription

Fax to Program Pharmacy

Physician Completes

MD Name: DR JENNIFER ROTSTEIN

Address: 7 - 383 MAIN ST NORTH, MARKHAM, ON L3P 1Z3

Tel: 416-817-5280 **Fax:** N/A

MD License #: 77810 **AGN #:** 655305

Patient Chart #: _____

Physician Order

Rx: _____ # of Vials Product Order # : 91223 UH

Physician signature: _____ Date: DD / MM / YY

Patient Name : _____ First Name _____ Last Name

Patient Completes

Patient Information

☐ Check box if information same as previous

Date of Birth: DD / MM / YY Gender: M ☐ F ☐

Address: _____ Apt. #: _____

City: _____ Province: _____ Postal Code: _____

Phone Numbers	Preferred line for being contacted
Home: ( ) -	☐
Work: ( ) -	☐
Cell: ( ) -	☐

Email: _____

Patient Insurance Information

☐ Check box if information same as previous

Insurance Company Name: _____

Primary Plan Holder's Name: _____ Relationship to Patient: _____

Carrier ID #: _____ Health Plan/Group ID #: _____ Patient ID #: _____

Secondary plan (if applicable)

Insurance Company Name: _____

Primary Plan Holder's Name: _____ Relationship to Patient: _____

Carrier ID #: _____ Health Plan/Group ID #: _____ Patient ID #: _____

Patient Payment Information

☐ Check box if information same as previous

Payment Card: ☐ Visa ☐ Mastercard

(Please note: Amerian Express is not accepted.)

Name on the Card: _____

Relationship to Card Holder: _____

Card Number: _____ - _____ - _____ - _____ Expiry Date: MM / YY

Patient Consent

By signing this form, I am consenting to allow the above physician to share my health and insurance information (including clinical notes) as necessary with the Program Pharmacy and its affiliated pharmacies to allow them to determine my coverage and/or bill my insurance company. I also consent to having the above physician act as my agent and to obtain BOTOX® on my behalf from Allergan Inc. as part of the BOTOX® Patient Program. I will provide my credit card information to the Program Pharmacy when they call and allow them or an affiliated pharmacy to act as an agent of the above physician in billing my card for the cost of the BOTOX® medication. I am further consenting to allow the Program Pharmacy to contact me from time to time for the purpose of gathering information on my treatment, its effectiveness and/or duration, my future intention to be re-treated and other matters related to my treatment, and to remind me of an appropriate time to rebook for my next treatment. I also consent to allow non-personally identifiable information about my treatment history and insurance coverage to be made available to Allergan Canada Inc., the Program sponsor. [You may revoke the consent at any time by mailing the Program Pharmacy (pharmacy name and address is on back in FAQ) a signed and dated request. Such revocation will exempt you from the program after it is received and processed but will not affect the earlier information provided under the previous consent conditions.]

_____

Patient Signature