



## Botulinum toxin acknowledgement - focal spasticity

### Important information

This form must be completed for patients who are to receive treatment for moderate to severe spasticity of the upper limb in adults following a stroke. This form is required to be completed before the initial treatment only, and must be signed in front of a witness (over 18 years of age).

### Assistance

If you need assistance completing this form or need more information call **1800 700 270** (call charges may apply) and select option 4, between 8.30 am to 5.00 pm EST, Monday to Friday, or go to [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) > **For health professionals** > **PBS** > **Specialised drugs (PBS) A-I** > **Botulinum toxin**

### Lodgement

Send the completed form to:

**Medicare Australia**

**Prior written approval of specialised drugs**

**Reply paid 9826**

**Hobart TAS 7001**

or fax to: **1300 154 190**

Print in **BLOCK LETTERS**

Tick where applicable

### Patient's details

1 Medicare/DVA card number

-  -  Ref no.

2 Mr  Mrs  Miss  Ms  Other

Family name

First given name

3 Date of birth  /  /

4 Date of stroke  /  /

### Patient's declaration

5 I understand that PBS subsidised treatment with botulinum toxin will stop if:

- I have received the lifetime maximum of four botulinum toxin treatments per upper limb
- I have failed to respond after two treatments.

I declare that:

- my provider has explained the nature of the ongoing monitoring and testing required to demonstrate an adequate response to therapy.

Authorised person's full name (if applicable)

Patient or authorised person's signature

Date

/  /

### Provider's details

6 Provider number

7 Family name

First given name

8 Work phone number

(  )

Fax number

(  )

### Provider's declaration and acknowledgement

9 I declare that I have explained to the patient:

- the circumstances governing PBS subsidised treatment with botulinum toxin for moderate to severe spasticity of the upper limb in adults following a stroke
- the nature of the ongoing monitoring and testing required to demonstrate an adequate and sustained response to therapy.

I acknowledge that:

- if the patient fails to respond (Modified Ashworth Scale must decrease by more than one in at least one joint) after two treatments, treatment will stop.

Provider's signature

Date

/  /

### Witness's acknowledgement

10 I have witnessed the signatures of **BOTH** the patient or authorised person and the provider.

Witness's full name (over 18 years of age)

Witness's signature

Date

/  /

### Privacy note

The information provided on this form will be used to assess eligibility of a nominated person to receive PBS subsidised treatment. The collection of this information is authorised by the *National Health Act 1953*. This information may be disclosed to the Department of Health and Ageing, Department of Veterans' Affairs, or as authorised or required by law.