Fax: 866-926-0463
Phone: 855-427-4682

Neuromuscular Disorder Enrollment Form for Migraine, Cervical Dystonia, Overactive Bladder

Please complete this form for OptumRx members needing a Botulinum prescription. This form helps OptumRx determine if the patient's condition meets drug policy guidelines for coverage of the medications listed below in the Prescription Information section. Please fll out the form completely. Any missing information may cause a delay in the coverage determination. **This form is not a valid prescription in Arizona or Virginia.**

✂ Please detach before submitting to a pharmacy – tear here.

PATIENT INFORMATION

Please complete the following or ***send patient demographic sheet***

Patient Name ______

Address ______

Address 2 ______

City, State, ZIP ______

Home Phone ______ Alternate Phone ______

DOB ______ Last Four of SS# ______ Gender ______

Language Preference: ☐ English ☐ Spanish ☐ Other ______

PRESCRIBER INFORMATION

Prescriber's Name ______

DEA ______

NPI ______

Group / Hospital ______

Address ______

City, State, ZIP ______

Phone ______ Fax ______

Contact Person ______ Phone ______

INSURANCE INFORMATION *(Fill out entirely or fax a copy of patient's insurance card including both sides)*

Prescription Card: Name of Insurer ______ ID # ______ BIN ______ PCN ______ Group ______

Primary Insurance: Subscriber ______ ID # ______ Name of Insurer ______ Phone ______

Secondary Insurance: Subscriber ______ ID # ______ Name of Insurer ______ Phone ______

CLINICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis – Please include diagnosis name with ICD-10 code

ICD-10 Code: ______ Diagnosis: ______

Therapy: ☐ New ☐ Reauthorization ☐ Restart Weight ______ kg / lbs Height ______ cm / in

Allergies ______ Accompanying Medications ______

☐ Yes ☐ No Does the provider attest to the member's medical record documenting both of the following?: 1. History and physical examination documenting the severity of the condition; and 2. Laboratory results or diagnostic evidence supporting the indication for which botulinum toxin is requested?

If restart or reauthorization

☐ Yes ☐ No Did the member have a positive clinical response to botulinum toxin therapy?

Migraine headache, chronic

☐ Yes ☐ No Does the member have all of the following: 1) Greater than or equal to 15 headache days per month, AND 2) Greater than or equal to 8 migraine days per month, AND 3) Headaches that last 4 hours per day or longer?

☐ Yes ☐ No Does the member have a history of failure (after a trial of at least two months), contraindication, or intolerance to prophylactic therapy with one agent from two of the following therapeutic classes: a) Antidepressant drug class b) Antiepileptic (anti-seizure) drug class c) Beta blocker drug class?

☐ Yes ☐ No Will Botox be used in combination with CGRP antagonists [i.e., Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab)]?

☐ Yes ☐ No Will the dose of OnabotulinumtoxinA exceed 155 units administered intramuscularly divided over 31 injection sites divided across 7 head and neck muscles every 12 weeks?

Cervical dystonia

☐ Yes ☐ No Does the member have the following symptom: Sustained head tilt or abnormal posturing resulting in pain and/or functional impairment?

☐ Yes ☐ No Does the member have the following symptom: recurrent involuntary contraction of one or more muscles of the neck (e.g., sternocleidomastoid, splenius, trapezius, posterior cervical)

Overactive bladder

☐ Yes ☐ No Does the member one of the following symptoms: Urge urinary incontinence, Urgency, or Frequency?

☐ Yes ☐ No Does member have history of failure, contraindication, or intolerance to two anticholinergic medications (Such as: darifenacin, fesoterodine, oxybutynin, solifenacin, tolterodine, trospium)?

☐ Yes ☐ No Will the dose of OnabotulinumtoxinA exceed 100 units divided over 20 injection sites every 12 weeks?

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions		Quantity	Refills
☐ Botox®	☐ 50 Unit Vial ☐ 100 Unit Vial ☐ 200 Unit Vial	☐ Inject__units IM into__every__(weeks/months).	To be given by MD in office, any unused portion to be discarded.		
☐ Dysport®	☐ 300 Unit Vial ☐ 500 Unit Vial	☐ Inject__units IM into__every__(weeks/months).	To be given by MD in office, any unused portion to be discarded.		
☐ Myobloc®	☐ 2,500 Unit Vial ☐ 5,000 Unit Vial ☐ 10,000 Unit Vial	☐ Inject__units IM into__every__(weeks/months).	To be given by MD in office, any unused portion to be discarded.		
☐ Xeomin®	☐ 50 Unit Vial ☐ 100 Unit Vial ☐ 200 Unit Vial	☐ Inject__units IM into__every__(weeks/months).	To be given by MD in office, any unused portion to be discarded.		

Ship to: ☐ Office ☐ Other ______ Date ______ Date Needed ______

*Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our sI authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.hared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Dispense as Written

Prescriber's Signature ______ Date ______
Electronic or digital signatures not accepted.

Substitution permitted

Prescriber's Signature ______ Date ______
Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.

This form is not a valid prescription in Arizona or Virginia.