OPTUM®

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

Neuromuscular Disorder Enrollment Form for Achalasia, Chronic Anal Fissure, Detrusor Overactivity, Spasticity, Bleopharospasm

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 fill out the form completely. Any missing information may cause a delay in the coverage determination.

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?

Achalasia:

☐ Yes ☐ No Diagnosis of achalasia has been confirmed by esophageal manometry?

☐ Yes ☐ No Has patient failed or is not a candidate for pneumatic dilation or myotomy?

☐ Yes ☐ No Does member has history of failure, contraindication, or intolerance to one of the following: A. Calcium channel blocker or B. Long-acting nitrate?

☐ Yes ☐ No Have other causes of dysphagia (e.g., peptic stricture, carcinoma, extrinsic compression) ruled out by upper gastrointestinal endoscopy?

Chronic anal fissure:

☐ Yes ☐ No Have the symptoms been ongoing for at least two months?

☐ Yes ☐ No Does member have one of the following: Nocturnal pain and bleeding OR Postdefecation pain?

☐ Yes ☐ No Does member have history of failure, contraindication, or intolerance to one of the following conventional therapies: A. Topical nitrate or B. Topical calcium channel blocker (diltiazem or nifedipine)

Detrusor Overactivity

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

Spasticity

☐ Yes ☐ No Spasticity associated with any of the following: cerebral palsy; multiple sclerosis; neuromyelitis optica (NMO); stroke or other injury, disease, or tumor of the brain or spinal cord?

Blepharospasm associated with Dystonia (non-Botox medication request)

☐ Yes ☐ No Does the member have a history of failure, contraindication, or intolerance to Botox (onabotulinumtoxinA)?

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 to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. 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.

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature _____ Date _____ Supervising physician _____ Date _____