



Fax: 866-926-0463
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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 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?

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
<input type="checkbox"/> Botox®	<input type="checkbox"/> 50 Unit Vial <input type="checkbox"/> 100 Unit Vial <input type="checkbox"/> 200 Unit Vial	<input type="checkbox"/> Inject ___units IM into ___every ___(weeks/months). <small>To be given by MD in office, any unused portion to be discarded.</small>		
<input type="checkbox"/> Dysport®	<input type="checkbox"/> 300 Unit Vial <input type="checkbox"/> 500 Unit Vial	<input type="checkbox"/> Inject ___units IM into ___every ___(weeks/months). <small>To be given by MD in office, any unused portion to be discarded.</small>		
<input type="checkbox"/> Myobloc®	<input type="checkbox"/> 2,500 Unit Vial <input type="checkbox"/> 5,000 Unit Vial <input type="checkbox"/> 10,000 Unit Vial	<input type="checkbox"/> Inject ___units IM into ___every ___(weeks/months). <small>To be given by MD in office, any unused portion to be discarded.</small>		
<input type="checkbox"/> Xeomin®	<input type="checkbox"/> 50 Unit Vial <input type="checkbox"/> 100 Unit Vial <input type="checkbox"/> 200 Unit Vial	<input type="checkbox"/> Inject ___units IM into ___every ___(weeks/months). <small>To be given by MD in office, any unused portion to be discarded.</small>		

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 _____

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.