OPTUM®

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 fill out the form completely. Any missing information may cause a delay in the coverage determination. **This form is not a valid prescription in Arizona.**

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 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 _____