



Fax: 866-926-0463
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Neuromuscular Disorder Enrollment Form for Achalasia, Chronic Anal Fissure, Detrusor Overactivity, Spasticity, Blepharospasm

Please complete this form for UnitedHealthcare commercial plan members needing a Botulinum prescription. This form helps UnitedHealthcare 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 have 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
<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 _____

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