Optum Specialty Phone: 855-427-4682
Optum Specialty Fax: 877-342-4596

Neuromuscular Disorder Enrollment Form

Specialty Pharmacy Enrollment Form Please detach before submitting to a pharmacy – tear here. **This form is not a valid prescription in Arizona or Virginia.**

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 *(Must fax a copy of patient's insurance card including both sides)*

Prior Authorization Reference number ____________________

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

Diagnosis — Please include diagnosis name with ICD-10 code

☐ Diagnosis: ICD-10 Code ________

Description ____________________

Date of Diagnosis ____________________

Estimated length of therapy ____________________

Additional Information

Therapy: ☐ New ☐ Reauthorization ☐ Restart

Weight ________ kg / lbs

Height ________ cm / in

Allergies ____________________

Lab Data ____________________

Prior Therapies ____________________

____

Concomitant Medications ____________________

____

Additional Comments ____________________

____

PRESCRIPTION INFORMATION

Medication	Dose / Strength	Directions		Quantity	Refills
☐ Botox®	☐ 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.		
		☐ 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 ____________ Needs by Date ____________

* 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 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.

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.

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