OPTUM®

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.		
		☐ 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 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 _____

Electronic or digital signatures not accepted.

Supervising Physician Signature: _____ Date _____