Fax: 866-926-0463

Phone: 855-427-4682

Neuromuscular Disorder Enrollment Form

Please complete this form for UnitedHealthcare commercial plan members needing a Botulinum prescription.
*Fax the completed form to BriovaRx at **866-926-0463**. BriovaRx will notify you and your patient of prescription coverage determination.*
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.
*If you have questions or need to request a refill, please contact BriovaRx at **855-427-4682**.*
Please fill out the form completely. Any missing information may cause a delay in the coverage determination.

For all REFILL requests, please call 855-427-4682

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: __________

ICD-10 Code: __________ Diagnosis: __________

ICD-10 Code: __________ Diagnosis: __________

Additional Information

Therapy: ☐ New ☐ Reauthorization ☐ Restart Weight __________ kg / lbs Height __________ cm / in

Allergies ____________________

Lab Data ____________________

Prior Therapies ____________________

Accompanying Medications ____________________

Additional Comments ____________________

Description __________ Date of Diagnosis __________ Estimated length of therapy __________

☐ Yes ☐ No Does patient suffer from headaches, of which at least 50% are migraine or probably migraine, 15 days or more per month?

☐ Yes ☐ No Do patient headaches last 4 hours per day or longer?

☐ Yes ☐ No Is this request for a botulinum toxin a new start? If no, Initiation Date: __________ Date of last dose: __________

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.		
		☐ 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 __________

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.