Neuromuscular Disorder Enrollment Form

A Dose Of Kindness With Every Perscription.

Ship to: ☐ Patient ☐ Office ☐ Other: Date: Needs by Date:

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 ______

PRESCRIBER INFORMATION

Prescriber's Name ______
State License # ______ UPIN ______
DEA ______ NPI ______
Group/Hospital ______
Address ______
City, State, ZIP ______
Phone ______ Fax ______
Contact Person ______ Phone ______

INSURANCE INFORMATION

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 ______

MEDICAL INFORMATION

Diagnosis

Please include diagnosis name and ICD-9

☐ 530.0 Achalasia
☐ 705.21/22 Hyperhidrosis*
☐ 333.81 Blepharospasm
☐ 343.0 Muscle Spasm with Cerebral Palsy
☐ 952.0 Cervical Dystonia
☐ 378.0 Strabismus
☐ 351.0 Facial Nerve (VII) Disorders
☐ Other: ICD-9 ______ Diagnosis ______

Date of Diagnosis ______

*For hyperhidrosis, did the patient try and fail a minimum 30-day course of therapy with Drysol or Xerac? ☐ Yes ☐ No

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			
☐ Dysport	☐ 300 Unit Vial ☐ 500 Unit Vial			
☐ Myobloc	☐ 2,500 Unit Vial ☐ 5,000 Unit Vial ☐ 10,000 Unit Vial			

Prescriber's Signature ______
PRODUCT SUBSTITUTION PERMITTED ______ *DISPENSE AS WRITTEN*

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