Neurology Prescription Form

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DATE:____________NEEDS BY DATE: ___________ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER ______________________________

PATIENT INFO		PRESCRIBER INFO		
Patient Name		Prescriber Name		
Address		DEA #	NPI #	License #
City, State, Zip		Address		
Main Phone	Alternate Phone	City, State, Zip		
Social Security #		Phone	Fax	
Date of Birth	❑ Male ❑ Female	Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis Code: ❑ 340.0 Multiple Sclerosis ❑ Other ____

History:
- Has the patient been previously treated for this condition? ❑ Yes ❑ No Medication failed ____________________
- Is the patient currently on therapy? ❑ Yes ❑ No Medication failed ____________________
- Will patient stop taking current therapy before starting new therapy? ❑ Yes ❑ No
- How long will the patient wait before starting the new therapy? ____________________________
- Are there other medications patient currently taking? Please list: ______________________________________

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Avonex®	❑ 30mcg Prefilled Syringe ❑ 30mcg Vials	❑ Inject 30mcg intramusculary once weekly ❑ Other dosing: ______________________________	4 week supply	________
❑ Betaseron®	❑ 0.3mg Prefilled Syringe	❑ Initial: Week 1&2: 0.0625mg (0.25ml), Week 3&4: 0.125mg (0.5ml), Week 5&6: 0.1875mg (0.75ml), Week 7+: 0.25mg (1ml) SubQ every other day ❑ Maintenance: Inject 0.25mg (1ml) subcutaneously every other day	4 week supply	________
❑ Copaxone®	❑ 20mg Prefilled Syringe	❑ Inject 20mg subcutaneously once every day	4 week supply	________
❑ Extavia®	❑ 0.3mg Kit	❑ Inject 0.25g subcutaneously every other day	4 week supply	________
❑ Gilenya®	❑ 0.5mg Capsule	❑ Take 1 capsule by mouth daily	4 week supply	
❑ Rebif®	❑ Titration Pack ❑ 22mcg Prefilled Syringe ❑ 44mcg Prefilled Syringe	❑ Initial: Inject - Week 1&2: 8.8mcg (0.2ml), Week 3&4: 22mcg (0.5ml) subcutaneously three times weekly 48hrs apart ❑ Maintenance: Inject 22mcg (0.5ml) subcutaneously three times weekly 48hrs apart ❑ Maintenance: Inject 44mcg (0.5ml) subcutaneously three times weekly 48hrs apart ❑ Other dosing: ______________________________	4 week supply	________

❑ Other ____

❑ Epipen® ❑ Epipen Jr.®		❑ Inject 1 pen into thigh area in case of anaphylaxis; may repeat	2 pen pack	________

By signing this form, Cienega Pharmacy and it's staff are authorized to serve as your prior authorization designated agent for medical and prescription insurance companies.

_______________________ Prescriber's Signature (no stamps)

__________ Date

__________________ If Brand required check ❑ DAW

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