P: 832-813-8932

F: 888-883-9901

NEUROLOGY RX FORM

PATIENT INFORMATION

PATIENT NAME: _____ **DOB** _____/_____/_____ **PHONE:** (_____) - _____ - _____

PLEASE ATTACH A COPY OF THE PATIENT'S INSURANCE INFORMATION AND DEMOGRAPHICS

MEDICATION

☐ DEPACON 500MG IV DAILY FOR _____ DAYS

☐ SOLUMEDROL 125MG IV DAILY FOR _____ DAYS

☐ MAGNESIUM SULFATE _____MG IV DAILY FOR _____ DAYS

☐ DEXAMETHASONE _____ MG IV DAILY FOR _____DAYS

☐ VYEPTI 100 MG IV every 3 months
☐ VYEPTI 300 MG IV every 3 months

PRE-MEDICATIONS

BENADRYL IV _____ MG
REGLAN IV _____ MG
SOLUMEDROL IV _____ MG
ZOFRAN IV _____ MG
OTHER IV_____ MG

BENADRYL PO _____ MG
TYLENOL PO _____ MG
ZYRTEC PO _____ MG
ZOFRAN PO _____ MG
ZANTAC PO _____ MG
OTHER PO_____ MG

INDICATE IF ADDITIONAL PRE-MEDS ARE NEEDED

☐ **PERIPHERAL IV CAN BE LEFT IN UNTIL TREATMENT COMPLETED**

MEDICAL INFORMATION

WEIGHT: _____**LBS**

ALLERGIES: _____ ☐ **N.K.D.A**
_____

PREVIOUSLY FAILED MEDICATIONS/DOSE:

#1 _____ **DATE RANGE:** _____

#2_____ **DATE RANGE:** _____

PATIENT WILL BE DISCONTINUING: _____

PLEASE ATTACH ALL MEDICAL RECORDS, INCLUDING LAB WORK, CLINICAL NOTES, HOSPITALIZATION RECORDS, OR SURGICAL PROCEDURES

DIAGNOSIS

G43. _____ - _____

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing our company (based on preferred location) and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

PHYSICIAN NAME (PRINTED): _____ **NPI:** _____

PHONE: _____ **FAX:** _____ **CONTACT PERSON:** _____

PHYSICIAN NAME (SIGNED): _____ **DATE:** _____