



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: _____

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