P: 832-813-8932

F: 888-883-9901

NEUROLOGY RX FORM

PATIENT INFORMATION

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

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

MEDICATION

☐ TYSABRI 300MG IV EVERY 4 WEEKS
*PREMEDICATE: TYLENOL 1000MG PO, BENADRYL 25MG PO

☐ OCREVUS 300MG IV AT WEEKS 0 AND 2
☐ OCREVUS 600MG IV EVERY 6 MONTHS, FOR A TOTAL OF 2 INFUSIONS
*PREMEDICATE: SOLUMEDROL 100MG IV 30 MIN PRIOR
BENADRYL 25MG PO, TYLENOL 500MG PO

☐ SOLUMEDROL 1GM IV DAILY FOR g _____ DAYS
☐ PERIPHERAL IV CAN BE LEFT IN UNTIL TREATMENT COMPLETED

☐ RADICAVA 60MG IV DAILY FOR 14 DAYS, FOLLOWED BY 14 DAYS OFF
☐ RADICAVA 60 MG IV DAILY FOR 10/14 DAYS, FOLLOWED BY 14 DAYS OFF
☐ PERIPHERAL IV CAN BE LEFT IN UNTIL TREATMENT COMPLETED

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

☐ REFILLS
☐ 6 MONTHS
☐ 1 YEAR

PRE-MEDICATIONS

BENADRYL IV g ____ MG
REGLAN IV g ____ MG
SOLUMEDROL IV g ____ MG
ZOFRAN IV g ____ MG
OTHER IV g _____ MG

BENADRYL PO g ____ MG
TYLENOL PO g ____ MG
ZYRTEC PO g ____ MG
ZOFRAN PO g ____ MG
ZANTAC PO g ____ MG
OTHER PO g _____ MG

INDICATE IF ADDITIONAL PRE-MEDS ARE NEEDED

IF APPLICABLE, DATE OF LAST INFUSION: g _____

WILL PATIENT BE RE-LOADING? ☐ **YES** ☐ **NO**

MEDICAL INFORMATION

WEIGHT: g _____ **LBS** **HEIGHT:** g _____ **IN**
ALLERGIES: g _____ ☐ **N.K.D.A**

DATE OF MRI (OCREVUS, TYSABRI)**:** g _____
DATE OF EMG (RADICAVA)**:** g _____

DATE OF HEP PANEL (OCREVUS ONLY)**:** g _____
RESULT: ☐ **NEGATIVE** ☐ **POSITIVE**

DATE OF JCV ANTIBODY (TYSABRI ONLY)**:** g _____
RESULT: ☐ **NEGATIVE** ☐ **POSITIVE**

PREVIOUSLY FAILED MEDICATIONS/DOSE:

#1 g _____ **DATE RANGE:** g _____
#2 g _____ **DATE RANGE:** g _____
#3 g _____ **DATE RANGE:** g _____

PATIENT WILL BE DISCONTINUING: g _____

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

DIAGNOSIS

MULTIPLE SCLEROSIS

☐ G35 MULTIPLE SCLEROSIS

*SELECT ONE OF THE FOLLOWING:
☐ RELAPSING-REMITTING
☐ PRIMARY-PROGRESSIVE
☐ SECONDARY-PROGRESSIVE
☐ PROGRESSIVE-RELAPSING

OTHER DIAGNOSIS

☐ OTHER DIAGNOSIS: g _____
ICD-10: g _____

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): g _____ **NPI:** g _____

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

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