PHARMACY SPECIALISTS
Your Partner in HealthCare

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Neurology Referral Form

DATE: **NEEDS BY DATE:** **SHIP TO** (circle one) **PATIENT HOME** **or** **MD OFFICE** **or** **OTHER**_____

PATIENT INFORMATION

Patient Name_____

Address _____

City, State, ZIP _____

Home Phone _____

Alternate Phone_____

Social Security Number _____Gender_____

PRESCRIBER INFORMATION

Prescriber Name_____

Address_____

City, State ZIP _____

Phone_____Fax_____

Contact Person_____

DEA #_____ NPI_____

INSURANCE INFORMATION: (Please send over a copy of the front and back of insurance and prescription cards)

CLINICAL INFORMATION

Diagnosis: _____ 340 Multiple Sclerosis, _____ Other

History: Date of Diagnosis_____

Medications Tried/Failed with Dates: _____

Other Medications: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	SIG	QTY	REFILLS
Avonex PFS	30mcg	Inject 30mcg QW	___FOUR___	_____
Avonex Pen Kit	30mcg	Inject 30mcg QW	___FOUR___	_____
Avonex Vials	30mcg	Inject 30mcg QW	___FOUR___	_____
Betaseron PFS	0.3mg	Initial – Weeks 1 & 2- 0.25ml SQ QOD Weeks 3 & 4- 0.5ml SQ QOD Weeks 5 & 6- 0.75ml SQ QOD Maintenance – Weeks 7 and thereafter – 1ml SQ QOD	_FOURTEEN_	_____
Copaxone PFS	20mg	Inject 20mg SQ QD	__THIRTY__	_____
Copaxone PFS	40mg	Inject 40mg SQ TIW (M,W,F)	__TWELVE__	_____
Extavia	0.3mg	Initial – Weeks 1 & 2- 0.25ml SQ QOD Weeks 3 & 4- 0.5ml SQ QOD Weeks 5 & 6- 0.75ml SQ QOD Maintenance – Weeks 7 and thereafter – 1ml SQ QOD	__FIFTEEN__	_____
Rebif Titration Pack	Titration	Weeks 1 & 2-Inject 8.8mcg TIW; Weeks 3 & 4 Inject- 22mcg TIW	___ONE____	ZERO
Rebif PFS	**22mcg**	Inject 22mcg SQ TIW (M,W,F)	__TWELVE__	_____
Rebif PFS	**44mcg**	Inject 22mcg SQ TIW (M,W,F)	__TWELVE__	_____
Gilenya	0.5mg	One capsule PO QD	_____	_____
Other:				
_____		_____	_____	_____

_____ _____

Prescriber Signature Date Dispense As Written? (Please write DAW)