NEUROLOGY
Referral Form

Phone: (818) 390-9696 • Toll-Free: (855) 265-7850 • Fax: (855) 450-6717 • info@MedicoRx.com

Today's Date: ____________________ Needs By Date: __________________________ SHIP TO: ❑ Patient ❑ Office ❑ Other______________________________

PATIENT INFORMATION			PRESCRIBER INFORMATION	
PATIENT NAME			**PRESCRIBER NAME**	
ADDRESS			**NPI#**	
CITY, STATE, ZIP			**DEA#**	**LICENSE#**
MAIN PHONE#	**ALT.#**		**ADDRESS**	
SOCIAL SECURITY#			**CITY, STATE, ZIP**	
DATE OF BIRTH		**❑ MALE ❑ FEMALE**	**PHONE#**	**FAX#**
HEIGHT	**WEIGHT**	**❑ LBS ❑ KG**		
ALLERGIES			**CONTACT PERSON**	
OTHER MEDICATIONS				

CLINICAL INFORMATION

Diagnosis Code: ❑ G35 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 medication patient currently taking?

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Avonex®	❑ 30mcg Prefilled Syringe ❑ 30mcg Vials	❑ Inject 30mcg intramuscularly once weekly ❑ Other dosing:	4 week supply	
❑ Betaseron®	❑ 0.3mg Prefilled Syringe	❑ Initial: Week 1&2: 0.0625mg (0.25 ml), 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 48hr 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	
❑ Tysabri	❑ 300mg-Vial	❑ 300mg IV Q 4 weeks		❑ Other

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

By signing this form and utilizing our services, you are authorizing MedicoRX and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

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Prescriber's Signature (no stamps) If Brand required check ❑ DAW__________ Initials__________ Date

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