RILUZOLE

Prescription 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: □ Huntington's Disease □ Tardive dyskinesia □ Other _____

Patient currently on therapy: □ Yes □ No Date of next blood work: _____

Prescription Information

RILUTEK® (Riluzole)

□ 50 mg tablets

30 Day Supply Quantity: _____ Refills: _____

90 Day Supply Quantity: _____ Refills: _____

Dosing:

□ 50mg PO twice daily (administer at least 1 hour before or 2 hours after a meal)

TIGLUTIK™ (Riluzole)

□ 50mg/10ml Oral Suspension

30 Day Supply Quantity: _____ Refills: _____

90 Day Supply Quantity: _____ Refills: _____

Dosing:

□ 50mg/10ml PO twice daily (administer at least 1 hour before or 2 hours after a meal)

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.

Prescriber's Signature (no stamps) □ DAW _____ Initials _____ Date _____