



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	<input type="checkbox"/> Male <input type="checkbox"/> Female	Phone#	Fax#
Height	Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg	Contact Person	
Allergies			
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) <input type="checkbox"/> 50 mg tablets 30 Day Supply Quantity: _____ Refills: _____ 90 Day Supply Quantity: _____ Refills: _____ Dosing: <input type="checkbox"/> 50mg PO twice daily (administer at least 1 hour before or 2 hours after a meal)	TIGLUTIK™ (Riluzole) <input type="checkbox"/> 50mg/10ml Oral Suspension 30 Day Supply Quantity: _____ Refills: _____ 90 Day Supply Quantity: _____ Refills: _____ Dosing: <input type="checkbox"/> 50mg/10ml PO twice daily (administer at least 1 hour before or 2 hours after a meal)
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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 _____

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