HAWAII SPECIALTY™ PHARMACY

Neurology Referral Form

Please complete and attach to MDX prior Authorization form

MDX Hawai'i

PATIENT INFORMATION:	PHYSICIAN INFORMATION:
Patient Name:	Physician Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: Alternate Phone:	Phone: Fax:
Email:	Office Email:
Soc. Sec #: Weight: ☐kg ☐lbs Height: ☐cm ☐ft	Key Office Contact:
Date of Birth: Sex: ☐ Male ☐ Female BSA:	State LIC # NPI # DEA#
Allergies:	

INSURANCE INFORMATION:

☐ Demographic sheet ☐ Universal claim form ☐ Insurance cards

*Please include demographic sheet along with Universal Claim Form for insurance records or reimbursement. (Attach Copies of cards)

DIAGNOSTIC INFORMATION:

Diagnosis / ICD-10: ☐ G12.21 ☐ G43.711 ☐ G43.701 ☐ G43.719 ☐ G43.709 ☐ Other:

- Has patient been treated previously for this condition? ☐ Yes ☐ No Medication(s) failed:
- Is patient currently on therapy? ☐ Yes ☐ No Type /medication(s):
- Prescription/Non-Prescription Medications:

MEDICATIONS AND DIRECTIONS

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
☐ **Aimovig®**	☐ 70 mg/mL	☐ Inject **one** 70mg/mL SureClick® pen subcutaneously once a month	☐ 4 week supply	
		☐ Inject **two** 70mg/mL SureClick® pens (140mg) subcutaneously once a month	☐ 4 week supply	
☐ **Botox®**	☐ 100 unit vial			
	☐ 200 unit vial			
☐ **Radicava®**	☐ 30mg/100mL	**Induction Dose:**		
		☐ 60mg IV over 60 minutes daily for 14 days followed by a 14 day drug-free period	☐ 4 week supply	
		Maintenance Dose:		
		☐ 60mg IV over 60 minutes daily for 10 days within a 14 day period, followed by a 14 day drug-free period	☐ 4 week supply	
☐ **Xeomin®**	☐ 50 unit vial			
	☐ 100 unit vial			
	☐ 200 unit vial			
☐ **Other**				

Prescriber Signature Required ****Prescription is void if the number of drugs prescribed is not noted***

I authorize Hawaii Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

PRESCRIBER SIGNATURE	DATE	NO. OF DRUGS PRESCRIBED _____ ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
X		