



Neurology Referral Form
*Please complete and attach to MDX prior
 Authorization form*



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: ___ <input type="checkbox"/> kg <input type="checkbox"/> lbs Height: ___ <input type="checkbox"/> cm <input type="checkbox"/> ft	Key Office Contact: _____
Date of Birth: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female BSA: _____	State LIC # _____ NPI # _____ DEA# _____
Allergies: _____	

INSURANCE INFORMATION:
<input type="checkbox"/> Demographic sheet <input type="checkbox"/> Universal claim form <input type="checkbox"/> 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: <input type="checkbox"/> G12.21 <input type="checkbox"/> G43.711 <input type="checkbox"/> G43.701 <input type="checkbox"/> G43.719 <input type="checkbox"/> G43.709 <input type="checkbox"/> Other: _____
▪ Has patient been treated previously for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication(s) failed: _____
▪ Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Type /medication(s): _____
▪ Prescription/Non-Prescription Medications: _____

MEDICATIONS AND DIRECTIONS				
MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILL
<input type="checkbox"/> Aimovig®	<input type="checkbox"/> 70 mg/mL	<input type="checkbox"/> Inject one 70mg/mL SureClick® pen subcutaneously once a month <input type="checkbox"/> Inject two 70mg/mL SureClick® pens (140mg) subcutaneously once a month	<input type="checkbox"/> 4 week supply	
<input type="checkbox"/> Botox®	<input type="checkbox"/> 100 unit vial <input type="checkbox"/> 200 unit vial			
<input type="checkbox"/> Radicava®	<input type="checkbox"/> 30mg/100mL	Induction Dose: <input type="checkbox"/> 60mg IV over 60 minutes daily for 14 days followed by a 14 day drug-free period Maintenance Dose: <input type="checkbox"/> 60mg IV over 60 minutes daily for 10 days within a 14 day period, followed by a 14 day drug-free period	<input type="checkbox"/> 4 week supply	
<input type="checkbox"/> Xeomin®	<input type="checkbox"/> 50 unit vial <input type="checkbox"/> 100 unit vial <input type="checkbox"/> 200 unit vial			
<input type="checkbox"/> 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 _____ <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5
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