VERBAL ORDER FORM
NEUROLOGY

QuickRX SPECIALTY PHARMACY

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Ph 347-691-3494 | Fax 347-691-3496
NPI# 1003148321 NCPDP# 3364471
info@QuickRxSpecialty.com

Today's Date _____
Date Needed _____

☐ Phone Order
Ship to Patient:
☐ Home ☐ Work
Ship to:
☐ Physician Office
☐ Nurse / Training
☐ QuickRX Pharmacy

Patient Name_____ Date of Birth_____ ☐ Male ☐ Female
Address_____ Apt #_____ City_____ State____ Zip_____
Telephone_____ Cell_____ SSN_____ Email_____
Allergies_____ Comorbidities_____
Current medications (including OTC) w/ dosage & direction (or fax medication) _____

Primary Insurance_____ ID#_____ Group #_____
Insured's Name_____ Employer_____
City_____ State_____ Phone_____

ICD-10 Diagnosis Code ☐ **G35** Multiple Sclerosis ☐ **G43** Migraine ☐ **G20** Parkinson's disease ☐ Other Diagnosis_____
Type: ☐ Relapsing-remitting ☐ Primary progressive ☐ Secondary progressive ☐ Progressing Relapsing ☐ Other Diagnosis_____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed _____
Patient currently on therapy? ☐ Yes ☐ No Type/medication(s) _____
Will patient stop taking the medication(s) before starting the new medication? ☐ Yes ☐ No
If yes, how long should patient wait before starting the new medication? _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

MIGRAINE THERAPIES

☐ **AIMOVIG** ☐ 70mg/mL SureClick ☐ 140mg/mL SureClick ☐ 70mg/mL autoinjector (2-ct.)
SIG: Inject ☐ 70mg **OR** ☐ 140mg SQ once monthly QTY: ____ Refills: ____

☐ **AJOVY** 225mg/1.5mL PFS
☐ SIG: Inject 225mg SQ once monthly QTY: 1 PFS Refills: _____
☐ SIG: Inject 675mg SQ once every 3 months QTY: 3 PFS Refills: _____

☐ **EMGALITY** ☐ 100mg/mL PFS (3-ct.) ☐ 120mg/mL PFS ☐ 120mg/mL Pen
☐ nject 2 QTY: 2 Refills: 0
☐ Maintenance SIG: Inject 120mg SQ once monthly thereafter QTY: 1 kit Refills: ____
☐ Cluster period SIG: Inject 300mg SQ at onset of cluster period, then once monthly thereafter QTY: 3 Refills: _____

☐ **REYVOW** ☐ 50mg ☐ 100mg
SIG: Take 1 tablet by mouth at onset of migraine QTY: 8 Refills: ____

☐ **UBRELVY** ☐ 50mg tablet (1-ct. packet) ☐ 100mg tablet (1-ct. packet)
SIG: Take 1 tablet by mouth at onset of migraine, may repeat in 2 hours if needed
QTY: ☐ 6-pack box ☐ 8-pack box ☐ 10-pack box
☐ 12-pack box ☐ 30-pack box Refills: _____

HIGH-EFFICIENCY MS THERAPY

☐ **LEMTRADA** 12mg/1.2mL SDV ☐ Enroll in *MS One to One*
☐ Year 1: Infuse 12mg IV daily for 5 consecutive days QTY: 5 vials Refills: 0
☐ Year 2: Infuse 12mg IV daily for 3 consecutive days QTY: 3 vials Refills: 0

☐ **OCREVUS™** 300mg/10mL SDV ☐ Enroll in *OCREVUS CONNECTS*
☐ Starting dose: Infuse 300mg IV on Day 1, then infuse 300mg IV on Day 15
QTY: 2 vials Refills: 0
☐ Maintenance SIG: Infuse 600mg IV every 6 months thereafter
QTY: 2 vials Refills: _____

☐ **TYSABRI®** 300mg/15 ml SDV ☐ Enroll in *Tysabri TOUCH*
SIG:Infuse 300mg IV over 1 hour every 4 weeks QTY: 1 vial Refills: _____

☐ **RITUXAN** ☐ 100mg/10mL vial ☐ 500mg/50mL vial Weight: ____ kg
☐ Starter SIG: Infuse 375mg/m2 IV once weekly for 4 wks QTY: ___ vial(s) Refills: 0
☐ Maintenance SIG: Infuse 375mg/m2 IV once monthly (for 2 months)
QTY: _____ vial(s) Refills: 1
☐ Other SIG:_____ QTY: _____vial(s) Refills: _____

☐ **COPAXONE** ☐ **GLATOPA** ☐ **GLATIRAMER ACETATE**
☐ 20mg PFS (30-ct) ☐ 40mg PFS (12-ct)
☐ SIG: Inject 20mg SQ daily QTY: 30 Refills: ____
☐ SIG: Inject 40mg SQ TIW QTY: 12 Refills: ____
☐ DAW-1: Brand medically necessary ☐ Enroll in *Shared Solutions*

OTHER MEDICATION_____
SIG:_____ **QTY:**_____ **REFILL:**_____

ORAL MS THERAPY

☐ **GILENYA™** 0.5mg capsule ☐ Enroll in *GILENYA Go Program*
SIG: Take one capsule by mouth daily QTY: ☐ 30 ☐ 90 Refills: _____
☐ Starter Pack ☐ 0.25mg tablet ☐ 2mg tablet
SIG: _____ QTY: _____ Refills: _____
☐ Enroll in *Alongside MS*

INTERFERON MS THERAPY

☐ **AVONEX®** 30mcg/0.5mL ☐ Pen ☐ PFS ☐ Enroll in *MS ActiveSource*
SIG: Inject 30mcg IM once weekly QTY: 4 injections Refills: _____

☐ **REBIF®** ☐ **REBIDOSE®** ☐ Enroll in *MS Lifelines*
☐ 22mcg PFS ☐ 44mcg PFS ☐ Titration Pack 8.8mcg/22mcg
SIG: _____ QTY: 12-count Refills: _____

☐ **BETASERON®** 0.3mg vial with diluent syringe (14-ct) ☐ Enroll in *Beta Plus MS*

☐ **EXTAVIA** 0.3mg vial with diluent syringe (15-ct) ☐ Enroll in *Extavia Program*
SIG: _____ QTY: _____ Refills: _____
☐ Maintenance SIG: 0.25 mg (1ml) SQ every other day
☐ Other_____ QTY: 30 Day Supply Refills: _____

☐ **PLEGRIDY STARTER PACK** 63mcg/94mcg ☐ Pens ☐ PFS
☐ nject 63mcg SQ on Day 1, then inject 94mcg SQ
QTY: 1 kit Refills: 0 ☐ Enroll in *AboveMS*

☐ **PLEGRIDY** 125mcg ☐ Pens ☐ PFS QTY: 2 Refills: _____ ☐ Enroll in *AboveMS*
☐ SIG: Inject 125mcg SQ

PARKINSON'S DISEASE THERAPIES

☐ **NOURIANZ** ☐ 20mg tablet ☐ 40mg tablet
SIG: Take 1 tablet by mouth daily QTY: 30 Refills: _____

SUPPORTIVE THERAPY

☐ **AMPYRA®** 10mg ER 12-hour tablet ☐ Enroll in *Ampyra Patient Support Services*
SIG: Take one tab by mouth twice daily QTY: ☐ ☐ 120 Refills: _____

☐ **ACTHAR GEL®** 80units/mL (5mL MDV)
SIG: _____ QTY: _____ Refills: _____

Prescriber's Name / Practice _____ Office Contact_____
Address_____ Suite#_____ City_____ State____ Zip_____
Tel_____ Fax_____ Email_____
License#_____ NPI#_____ UPIN#_____ DEA#_____

Prescriber's Signature (signature required. NO STAMPS)_____ **Date**_____

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

Please fax completed referral form to **QuickRx** at **347-691-3496**
Visit us at **quickrxspecialty.com** for online fillable forms.