GLESENER PHARMACY

Celebrating 80 Years! Serving the Community Since 1937

NEUROLOGY REFERRAL FORM

Phone: (626) 966-3691 • Fax: (626) 331-8691 • Dedicated Texting: (626) 664-0988

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: ❑ G35 Multiple Sclerosis ❑ Other _____

History:
- Has the patient been previously treated for this condition? ❑ Yes ❑ No Medication failed _____
- Is the patient currently on therapy? ❑ Yes ❑ No Medication failed _____
- Will patient stop taking current therapy before starting new therapy? ❑ Yes ❑ No
- How long will the patient wait before starting the new therapy? _____ •

Are there other medication patient currently taking?

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
❑ Avonex®	❑ 30mcg Prefilled Syringe ❑ 30mcg Vials	❑ Inject 30mcg intramuscularly once weekly Other dosing:	4 week supply	
❑ Betaseron®	❑ 0.3mg Prefilled Syringe	❑ Initial: Week 1&2: 0.0625mg (0.25 ml), Week 3&4: 0.125mg (0.5ml), Week 5&6: 0.1875mg (0.75ml), Week 7: 0.25mg (1ml) SubQ every other day. ❑ Maintenance: Inject 0.25mg (1ml) subcutaneously every other day	4 week supply	
❑ Copaxone®	❑ 20mg Prefilled Syringe	❑ Inject 20mg subcutaneously once every day	4 week supply	
❑ Extavia®	❑ 0.3mg Kit	❑ Inject 0.25g subcutaneously every other day	4 week supply	
❑ Gilenya®	❑ 0.5mg Capsule	❑ Take 1 capsule by mouth daily	4 week supply	
❑ Rebif®	❑ Titration Pack ❑ 22mcg Prefilled Syringe ❑ 44mcg Prefilled Syringe	❑ Initial: Inject – Week 1&2: 8.8mcg (0.2ml), Week 3&4: 22mcg (0.5ml) subcutaneously three times weekly 48hrs apart ❑ Maintenance: Inject 22mcg (0.5ml) subcutaneously three times weekly 48hr apart ❑ Maintenance: Inject 44mcg (0.5ml) subcutaneously three times weekly 48hrs apart ❑ Other dosing:	4 week supply	
❑ Other				
❑ Epipen® ❑ Epipen Jr.®		❑ Inject 1 pen into thigh area in case of anaphylaxis; may repeat	2 pen pack	
❑ Tysabri	❑ 300mg-Vial	❑ 300mg IV Q 4 weeks		❑ Other

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

Prescriber Authorization: I authorize Glesener Pharmacy and its representatives to act as my authorized agent to initiate the insurance prior authorization process for my patient(s), and to sign any necessary prior authorization forms on my behalf. In the event that Glesener Pharmacy is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Prescriber's Signature (no stamps) If Brand required check DAW_____ Initials_____ **Date**