MAIN POINT OF CONTACT

Name:_____

Phone:_____

ASP CARES

NEUROLOGY

Ph: (214) 919-2090 or (877) 753-6878

Fax: 1 (888) 294-9434

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____lbs.

Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:_____ Secondary Insurance:_____

ID#:_____ RxBin:_____ ID#:_____ RxBin:_____

RxGroup:_____ Pcn:_____ RxGroup:_____ Pcn:_____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Medication	Dose/Strength	Directions	Qty	Refills
☐ Avonex Powder Vial	30 mcg			
☐ Avonex Prefilled Syringe	30 mcg			
☐ Betaseron	0.3 mg			
☐ Copaxone	40 mg Pre-filled Syringe			
☐ Extavia	0.3 mg			
☐ Gilenya	0.5 mg			
☐ Rebif Titration Pack Box (12 syringes)	☐ 8 mcg ☐ 22 mcg ☐ 44 mcg			
☐ Rebif Box (12 syringes)	☐ 22 mcg/0.5ml ☐ 44 mcg/0.5ml			
☐ Tysabri	☐ 300 mg/15ml (20mg/ml)			

℞

Allergies:

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Phone:_____ Fax:_____

***Prescriber Signature:_____Date:_____**

Please fax completed form to 1 (888) 294-9434