



# NEUROLOGY ENROLLMENT FORM

Fax to: 817-332-5363

PHARMACY LOCATION  
Phone: 817-335-5712  
Fax: 817-332-5363  
800 8th Avenue, Suite 130  
Fort Worth, TX 76104

DATE: \_\_\_\_\_ SHIP TO:  
DATE NEEDED: \_\_\_\_\_  PATIENT  OFFICE

**PATIENT INFO**  
NAME \_\_\_\_\_ E-MAIL \_\_\_\_\_ DOB \_\_\_\_\_  MALE  FEMALE  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME TELEPHONE \_\_\_\_\_ MOBILE PHONE \_\_\_\_\_ SS# \_\_\_\_\_

**PLEASE FAX CLINICAL NOTES, LABS, TEST RESULTS WITH REFERRAL FORM AND COPY OF INSURANCE CARD (FRONT & BACK)**

**Diagnosis** Date of Diagnosis \_\_\_\_\_  G35 Multiple Sclerosis – Type:  Relapsing-remitting  Primary progressive  Secondary progressive  Clinically isolated syndrome (CIS)  
 G43.7 Chronic Migraine without aura (>15 days/month)  G24.3 Cervical Dystonia  N31.9 Neurogenic bladder  Other: \_\_\_\_\_

**Treatment History** Other medications patient is currently taking, including OTCs, with dose & directions (or fax medication profile): \_\_\_\_\_

Has patient been treated previously for this condition?  Yes  No – Medication(s) failed: \_\_\_\_\_  
Is patient currently on therapy?  Yes  No – Type/medication: \_\_\_\_\_ Allergies: \_\_\_\_\_  NKDA  
Will patient stop taking above medication(s) before starting the new medication?  Yes  No – If yes, how long should patient wait before starting the new medication? \_\_\_\_\_  
HGT \_\_\_\_\_ inches WGT \_\_\_\_\_ kg or \_\_\_\_\_ lbs Date of last MRI: \_\_\_\_\_ Changes?  Yes  No Number of relapses in the past year: \_\_\_\_\_ Is patient pregnant or breastfeeding?  Yes  No

HUNTINGTON'S DISEASE	Directions	Quantity	BOTULINUM TOXIN	Directions	Quantity
<input type="checkbox"/> <b>Tetrabenazine</b> (gen. Xenazine®) <input type="checkbox"/> 12.5mg tablet <input type="checkbox"/> 25mg tablet	<input type="checkbox"/> <b>Initial Dose:</b> 12.5mg QAM; then increase to 12.5mg BID. Dose may be increased by 12.5mg each week, and should be individualized. <input type="checkbox"/> Take _____ tablets by mouth _____ times a day <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ tablets Refills _____	<input type="checkbox"/> <b>Myobloc®</b> <input type="checkbox"/> 2,500 units/0.5ml vial <input type="checkbox"/> 5,000 units/1ml vial <input type="checkbox"/> 10,000Units/2ml vial	<input type="checkbox"/> Inject _____ units IM divided among affected area(s) by physician ONLY. (NOTE: dose not recommended to be repeated within 12 weeks) <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ vials Refills _____

INTERFERON BETA 1A	Directions	Quantity	INTERFERON BETA 1B	Directions	Quantity
<input type="checkbox"/> <b>Avonex®</b> <input type="checkbox"/> 30mcg/0.5ml Pen <input type="checkbox"/> 30mcg/0.5ml Prefilled Syringe	<input type="checkbox"/> Inject 30mcg IM ONCE weekly <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 <input type="checkbox"/> _____ Refills _____	<input type="checkbox"/> <b>Betaseron®</b> <input type="checkbox"/> 0.3mg vial kit	<input type="checkbox"/> <b>Initial Titration Dose:</b> • Week 1-2: Inject 0.0625mg/0.25ml SC every OTHER day • Week 3-4: Inject 0.125mg/0.5ml SC every OTHER day • Week 5-6: Inject 0.1875mg/0.75ml SC every OTHER day • Week 7+: Inject 0.25mg/1ml SC every OTHER day <input type="checkbox"/> Other: _____ <input type="checkbox"/> <b>Maintenance Dose:</b> • Inject 0.25mg/1ml SC every other day <input type="checkbox"/> Other: _____	<input type="checkbox"/> 28-day supply (1 kit / 14 vials) <input type="checkbox"/> _____ Refills _____

Rebif® Prefilled Syringes	Rebif Rebidose® Autoinjector Pens
<input type="checkbox"/> <b>Initial Titration Dose:</b> <input type="checkbox"/> Titration Pack (8.8mcg / 22mcg PFS/Pens)	<input type="checkbox"/> <b>Initial Directions:</b> <input type="checkbox"/> Inject 4.4 mcg SC three times per week on weeks 1-2, then 11 mcg SC three times per week on weeks 3-4, then maintenance dosing <input type="checkbox"/> Inject 8.8mcg SC three times per week on weeks 1-2, then 22mcg SC three times per week on weeks 3-4, then maintenance dosing <input type="checkbox"/> Other: _____
<input type="checkbox"/> <b>Maintenance Dose:</b> <input type="checkbox"/> 22mcg/0.5ml PFS/Pens <input type="checkbox"/> 44mcg/0.5ml PFS/Pens	<input type="checkbox"/> <b>Maintenance Directions:</b> <input type="checkbox"/> Inject 22mcg SC three times per week (48 hrs apart) <input type="checkbox"/> Inject 44mcg SC three times per week (48 hrs apart) <input type="checkbox"/> Other: _____

GLATIRAMER	Directions	Quantity	ORAL THERAPY	Directions	Quantity
<input type="checkbox"/> <b>Copaxone®</b> <input type="checkbox"/> 20mg/mL Prefilled Syringe <input type="checkbox"/> 40mg/mL Prefilled Syringe	<input type="checkbox"/> Inject 20mg SC ONCE daily <input type="checkbox"/> Inject 40mg SC three times per week <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 kit / 30 syringes <input type="checkbox"/> 1 kit / 12 syringes <input type="checkbox"/> _____ Refills _____	<input type="checkbox"/> <b>Gilenya® (fingolimod)</b> <input type="checkbox"/> 0.5mg capsules	<input type="checkbox"/> Take 1 capsule by mouth ONCE daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 30 capsules <input type="checkbox"/> _____ Refills _____
<input type="checkbox"/> <b>Glatopa™</b> <input type="checkbox"/> 20mg/ml Prefilled Syringe	<input type="checkbox"/> Inject 20mg SC ONCE daily <input type="checkbox"/> Other: _____	<input type="checkbox"/> 1 kit / 30 syringes <input type="checkbox"/> _____ Refills _____	<input type="checkbox"/> <b>Mitoxantrone</b> (gen. Novantrone®) <input type="checkbox"/> 20mg/10ml vial <input type="checkbox"/> 25mg/12.5ml vial	<b>Dosing:</b> {12 mg/m <sup>2</sup> IV every 3 months.} <input type="checkbox"/> Administer _____ mg via IV infusion once every 3 months. <input type="checkbox"/> Other: _____	<input type="checkbox"/> _____ vials Refills _____

**NOTES / OTHER**  
\_\_\_\_\_  
\_\_\_\_\_

OTHER	Directions	Quantity	OTHER	Directions	Quantity
<input type="checkbox"/> _____ <input type="checkbox"/> _____ mg	_____	<input type="checkbox"/> _____ Refills _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ mg	_____	<input type="checkbox"/> _____ Refills _____

**INJECTION TRAINING**  Patient has received injection training  Physician Office to provide injection training  Pharmacy to provide injection training

**PRESCRIBER INFORMATION**  
Prescriber's Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
Office Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_ TAX ID #: \_\_\_\_\_ Medicaid Provider #: \_\_\_\_\_

PRESCRIBER'S SIGNATURE \_\_\_\_\_ (DATE) \_\_\_\_\_ \*IF BRAND DRUGS ARE PREFERRED, HANDWRITE "BRAND MEDICALLY NECESSARY" ABOVE  
I authorize the Pharmacy noted above and its representatives to act as an agent to initiate and execute the insurance prior authorization process.