Mercy LTC & Specialty Pharmacy

A Member of Mercy Pharmacy Group

NEUROLOGY	PATIENT PRESCRIPTION REFERRAL FORM:	Revised 09/16/2024
	Refer via phone at: 562-402-0542 or Refer via fax at: 562-402-4629 Today's Date: Need By: E-prescribing: NCPDP: __________ NPI: _________________	

Patient Demographics: (Provide the following or attach patient demographic sheet)

Patient Name:
Home Phone: Alt. Phone:
Date of Birth: SS #:
Address:
City, State, Zip:
Gender: Allergies:
Height: Weight:

Prescriber Office: (Please provide as much information as possible) Prescriber's Name:
NPI:
Phone:
Fax:
Specialty:
Tax ID#:
DEA:
Address:

Insurance Information: (Please copy and attach the front and back of the patient's insurance card)
Primary Insurance: Name of Insurer:
ID#: BIN#: PCN#: Group: Phone:
Secondary Insurance: Name of Insurer:
ID#: BIN#: PCN#: Group: Phone:

Medication Delivery: Infuse in MIC Patient Address Always to Physicians Office First fill to Physician's Office, refills to Patient Address Pick up at Pharmacy

Diagnostic Information:
Date of Diagnosis **OR** Years with Disease:

Injection Training & Educational Needs:
Specialty Pharmacy Injection Training Requested
Prescriber's office will train patient OR (please choose one)
Manufacturer's Patient Assistance Program Enrollment Requested
Prescriber's office already trained patient
Patient is already independently injecting

Requested Clinical Information (if applicable)
Does patient have a latex allergy? Yes No
Has Hepatitis B been ruled out? Yes No
Does patient have serious/active infection? Yes No
Has TB test been performed? Yes No
Patient diagnosed with Heart Failure? Yes No If Yes, Results:
Additional Comments:

Prior (Failed) Medications (Reason for DC)

DRUG NAME	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Ocrevus®	**Ocrevu**s : 300 mg/10 mL vial	**INITIAL DOSE:** Infuse 300 mg **IV** at week 0, 2 Other	**INITIAL DOSE (no refills):** 2 vials Other	
	Ocrevus : 300 mg/10 mL vial	**MAINTENANCE DOSE:** Infuse 600 mg **IV** 6 months after initial dose and every 6 months thereafter Other	**MAINTENANCE DOSE:** 2 vials Other	
Tysabri®	**Tysabri** 300 mg / 15 mL vial	Infuse 300 mg **IV** every 4 weeks Other	1 vial Other	
IVIG®	**Specify Brand**	**INITIAL DOSE:** Infuse 2 g/kg **IV** over 2-5 days Other infuse g/kg **IV** over day/s	**INITIAL DOSE (no refills):** total of gram	
	Specify Brand	**MAINTENANCE DOSE:**	**MAINTENANCE DOSE:**	

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		Infuse 1 g/kg **IV** over day/s every week/s Other infuse g/kg **IV** over day/s every week/s	total of gram	
SCIG®	**Specify Brand**	Infuse g/kg **SQ** every week/s	total of gram	
Kisunla®	**Kisunla** 350mg/20ml	**INITIAL DOSE:** Infuse 700mg **IV** every 4 weeks for 3 doses Other	**INITIAL DOSE (no refills):** 6 vials Other	
	Kisunla 350mg/20ml	**MAINTENANCE DOSE:** Infuse 1400 mg **IV** every 4 weeks Other	**MAINTENANCE DOSE:** 4 vials Other	
Uplizna®	**Uplizna** 100 mg/10 ml	**INITIAL DOSE:** Infuse 300 mg **IV** at week 0, 2 Other	**INITIAL DOSE (no refills):** 6 vials Other	
		MAINTENANCE DOSE: Infuse 300 mg **IV** 6 months after initial dose and every 6 months thereafter Other	**MAINTENANCE DOSE:** 3 vials Other	
Humira®	Please specify how many mg/dose Pen or Prefilled Syringe Citrate free or not Other	Inject 40 mg **SQ** every OTHER week Other	4 week supply Other	
Physician Signature:		•DAW (Dispense as Written):	**Date:**	

Patient Support Programs: I authorize **Mercy Pharmacy Group** to enroll me in a company-assisted patient support program, corresponding with my prescribed therapy for purposes of receiving additional services such as, but not limited to injection training. I further authorize the release to communicate to the corresponding manufacturer the minimum necessary information about my health condition and prescription(s) to: coordinate the delivery of products and services available through the patient assistance program, aggregate de-identified data for market analysis and provide educational information regarding therapies. I understand that I may refuse t o sign this authorization and that my refusal will
not affect my ability to obtain treatment from the pharmacy. However, I will not be enrolled in the service program listed above, A copy of this authorization will be utilized with the same effectiveness as an original. Ancillary supplies provided as needed for administration

***Patient Signature:** (required for participation) **Date:** •Please select if you would like the patient enrolled in a Manufacturer's Assistance Program **CONFIDENTIALITY NOTICE:** If you are not the intended recipient or the person responsible for delivering it to the intended recipient, you are hereby notified that you are not authorized to read, print, retain, copy or disseminate this message, any part of it, or any attachments. This facsimile message may contain information that is confidential, privileged, proprietary, or otherwise legally exempt from disclosure or use. **Any disclosure or use of this facsimile message by any person other than the intended recipient or person responsible for delivering it to the intended recipient may constitute aFederal criminal offense punishable by imprisonment up to 10 years or fines up to $250,000.** If you have received this message in error, please destroy this message and any accompanying attachments in their entirety without reading the content and notify the sender immediately by telephone of the inadvertent transmission, by calling collect if located outside the calling area. There is no intent on the part of the sender to waive any right or privilege that may be attached to *