SUPERIOR SPECIALTY PHARMACY

Transforming lives one patient at a time

NEUROLOGY REFERRAL FORM

Phone: 813-960-2020
Fax: 813-549-3810
Toll Free: 877-436-2020

Ship To: ☐ Patient ☐ Physician/Clinic Date Shipment Needed: _____

Patient Information

Date: _____ Patient SS#: _____ ☐ Male ☐ Female

Patient's First Name: _____ Patient's Last Name: _____

Address: _____ City/County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ Caregiver: _____

Allergies: _____

ICD-9 Code: _____ Secondaty ICD-9: _____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (BOTH FRONT & BACK)
IF AVAILABLE, NAME & PHONE NUMBER OF LOCAL PHARMACY: _____

Prescriber Information

Drug Name	SIG/Directions	Other SIG	Quantity	# of Refills
☐ Copaxone 20mg	Inject 20mg SQ daily	_____	1 kit=30 prefilled syringes	_____
☐ Autoject 2 for glass syringe injection device/PRN	(to be provided by Shared Solutions)			
☐ Enroll in Shared Solutions/Needs Nurse Training				
☐ Avonex PFS 30mcg	Inject 30mcg IM once daily	_____	1 kit=4 prefilled syringes	_____
☐ Avonex SDV 30mcg	Inject 30mcg IM once daily	_____	1 kit=4 single dose vials	_____
☐ Enroll in MS Active Source/Needs Nurse Training				
☐ Betaseron 0.3mg		_____	1 kit=15 prefilled syringes	_____
☐ Sig. Titrations Per Package Insert: Weeks 1-2 0.0625mg/0.25ml SQ QOD; Weeks 3-4 0.125mg/0.50ml SQ QOD; Weeks 5-6 0.1875mg/0.75ml SQ QOD; Weeks 7+ 0.25mg/1ml SQ QOD	☐ No Titration Dose: 0.25mg (1ml) SQ QOD ☐ Other Sig: _____			
☐ Enroll in MS Pathways/Needs Nurse Training				
☐ Rebif Titration Pack	Inject 8.8mcg (0.2 ml) SQ three times weekly for week 1-2 and 22mcg (0.5ml) SQ three times weekly for week 3-4	_____	1 kit== 6 x 8.8mcg syringes and 6 x 22mcg syringes	_____
☐ Rebif 22mcg/0.5ml	Inject 8.8mcg (0.2 ml) SQ three times weekly for week 1-2 and 22mcg (0.5ml) SQ three times weekly for week 3-4	_____	_____	_____
☐ Rebif 44mcg/0.5ml	Inject 44mcg (0.5ml) SQ three times weekly	_____	_____	_____
☐ Rebif _____	_____	_____	_____	_____
☐ Enroll in MS Lifelines/Needs Nurse Training				
☐ Botox 100 units/vials		_____	_____	_____
☐ Myobloc 500 units/ml		_____	_____	_____
☐ Other _____	_____	_____	_____	_____
☐ Other _____	_____	_____	_____	_____

Prescriber Information

Physician: _____

Contact Name: _____ Phone #: _____ Fax #: _____ NPI #: _____

Office Address: _____ City: _____ State: _____ Zip: _____

License #: _____ UPIN #: _____ Medical Provider #: _____

Physician's Signature: _____ M.D. DEA #: _____ Date: _____

☐ **NO SUBSTITUTION** – Substitution Permissible unless practitioner checks this box.

I authorize Superior Specialty Pharmacy to enroll me in the manufacturer's patient support program, corresponding with my prescribed course of therapy with (Shared Solutions for Copaxane at Teva Neuroscience ___Initial, ___MS Pathways for Betaseronby Berlev ___(Initial), or MS Lifelines for Revif at Serono ___Initial, for purposes of receiving additional services such as, but not limited to; coordinate the delivery of products and services available through the patient support program, aggregate de-identified data for maker analysis and provide educational information regarding multiple sclerosis therapies. I understand I may revoke this authorization at anytime in writing by sending a letter to 5416 Town N' Country Blvd., Tampa, FL 33615. I understand that I may refuse to sign this authorization and that refusal will not affect my ability to obtain treatment from the pharmacy, however, I will not be enrolled in the patient support program(s) listed above. A copy of this authorization may be used with the same effectiveness as an original.

Patient Signature: _____ Date: _____