DR. IKE'S PHARMACY
ADVANCED SPECIALTY PHARMACY

NEUROLOGY
REFERRAL FORM

Fax: **808.804.7717**

Ship To: ☐ Patient ☐ Physician/Clinic Date Shipment Needed:________________ **Rx:** ☐ New ☐ Refill ______________

Patient Information

Patient's Full Name: ________________________________

Address: ________________________________

City, State, Zip: ________________________________

Home Phone: ________________________________

Alt. Phone: ________________________________

Patient SS#: ________________________________

DOB: ________________________________

Allergies: ________________________________

Gender: ☐ Male ☐ Female

Diagnosis: ________________________ ***ICD9 Code:*** ________

Patient Weight: ______________ *Height:* ________________

Primary Insurance: ________________________________

ID#: ____________________ Phone: ____________________

Secondary Insurance: ________________________________

ID#: ____________________ Phone: ____________________

OR

PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

Medication	Dose	DIRECTIONS (Frequency of Administration)	QTY	Refills
☐ Avonex Powder Vial	30mcg			
☐ Avonex Prefilled syringe	30mcg			
☐ Betaseron	0.3mg			
☐ Copaxone	20mg			
☐ Extavia	0.3mg			
☐ Gilenya	0.5mg			
Patients will be enrolled in Novartis' Gilenya Go Program. Please submit a completed SRF with every new prescription				
☐ Rebif Titration Pack Box (12 syringes)	☐ 8mcg ☐ 22mcg ☐ 44mcg			
☐ Rebif Box (12 syringes)	☐ 22mcg/0.5ml ☐ 44mcg/0.5ml			
☐ Tysabri	☐ 300mg/15ml (20mg/ml)			
☐ I.V.I.G				
☐ Other				

Prescriber Information

Physician's Name (please print): ________________________________ NPI#: ____________________

Address: ________________________________ License#: ____________________

City, State, Zip: ________________________________ DEA#: ____________________

Phone: ____________________ Fax: ____________________ Contact Name: ____________________

Physician's Signature: ____ Date: ____________

I authorize Dr. Ike's Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This message is intended for use of only the named addressee and may contain information that is proprietary and confidential. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.