HOME PARENTERAL SERVICES

Neuromuscular Disorder

PHONE: **1-800-637-9201**
FAX: **1-417-269-0692**

Patient Information

Patient name: _____ DOB: _____
Sex: ❑ Female ❑ Male SSN: _____
Language: _____ Wt: _____ ❑kg ❑lbs Ht: _____❑cm ❑in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ❑ First Fill ❑ Always ❑ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ❑ _____ ❑ _____ Diagnosis Date: _____
ICD-10

Prior Therapy ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ❑ NKDA ❑ Other: _____

Prescription		Directions	Quantity	Refill
❑ **Aimovig**	70mg/ml Auto-injector	❑ Inject 70mg subq monthly	1x 70mg/ml Auto-injector	_____
		❑ Inject 140mg subq monthly	2 x 70mg/ml Auto-injectors	
❑ **Ajovy**	225mg/1.5 ml PFS	❑ Inject 225mg subq monthly	1x 225mg/1.5ml PFS	_____
		❑ Inject 675mg subq every 3 months	3 x 225mg/1.5ml PFS	
❑ **Botox**	❑ 100 Unit Vial ❑ 200 Unit Vial	Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____
❑ **Dysport**	❑ 300 Unit Vial ❑ 500 Unit Vial	Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____
❑ **Emgality**	120mg/ml Auto-injector	❑ **Initial**: Inject 240mg subq as a single loading dose	2 x 120mg/ml Auto-injector	0
		❑ **Maintenance**: 120mg subq monthly	1 x 120mg/ml Auto-injector	_____
❑ **Myobloc**	❑ 2500 Unit Vial ❑ 5000 Unit Vial ❑ 10000 Unit Vial	Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____
❑ **Xeomin**	❑ 50 Unit Vial ❑ 100 Unit Vial ❑ 200 Unit Vial	Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____

Injection Training Provided by: ❑ Physican Office ❑ HPS ❑ Training not needed

Ship to: ❑ Patient ❑ Physican Office ❑ HPS

Prescriber's Signature: _____ Date: _____
Dispense as Written

_____
Substitution Permitted

I authorize Home Parenteral Services. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Home Parenteral Services.