



Neuromuscular Disorder

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

Patient Information		Prescriber + Shipping Information	
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> 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 name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never	
Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: <input type="checkbox"/> _____ <input type="checkbox"/> _____ Diagnosis Date: _____ ICD-10			
Prior Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
Comorbidities: _____			
Concomitant Medications: _____			
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Other: _____			
Prescription	Directions	Quantity	Refill
<input type="checkbox"/> Aimovig	70mg/ml Auto-injector <input type="checkbox"/> Inject 70mg subq monthly <input type="checkbox"/> Inject 140mg subq monthly	1x 70mg/ml Auto-injector 2 x 70mg/ml Auto-injectors	_____ _____
<input type="checkbox"/> Ajovy	225mg/1.5 ml PFS <input type="checkbox"/> Inject 225mg subq monthly <input type="checkbox"/> Inject 675mg subq every 3 months	1x 225mg/1.5ml PFS 3 x 225mg/1.5ml PFS	_____ _____
<input type="checkbox"/> Botox	<input type="checkbox"/> 100 Unit Vial <input type="checkbox"/> 200 Unit Vial Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____
<input type="checkbox"/> Dysport	<input type="checkbox"/> 300 Unit Vial <input type="checkbox"/> 500 Unit Vial Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____
<input type="checkbox"/> Emgality	120mg/ml Auto-injector <input type="checkbox"/> Initial: Inject 240mg subq as a single loading dose <input type="checkbox"/> Maintenance: 120mg subq monthly	2 x 120mg/ml Auto-injector 1 x 120mg/ml Auto-injector	0 _____
<input type="checkbox"/> Myobloc	<input type="checkbox"/> 2500 Unit Vial <input type="checkbox"/> 5000 Unit Vial <input type="checkbox"/> 10000 Unit Vial Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____
<input type="checkbox"/> Xeomin	<input type="checkbox"/> 50 Unit Vial <input type="checkbox"/> 100 Unit Vial <input type="checkbox"/> 200 Unit Vial Inject _____ units IM into _____ every _____ weeks (site)	_____ vials	_____
Injection Training Provided by: <input type="checkbox"/> Physician Office <input type="checkbox"/> HPS <input type="checkbox"/> Training not needed			
Prescriber's Signature: _____ Dispense as Written		Date: _____ 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.			

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