CoxHealth at Home

Neurology

PHONE:	1-855-419-4663
FAX:	1-417-269-0692

Patient Information			Prescriber + S	Shipping In	formation		
Patient name: DOB:			Prescriber name				
Sex: ☐ Female ☐ Male S			NPI:				
Language:			Address:				
Address:					State: Zip:		
Apt/Suite: City: State: Zip:			Contact:				
Phone: Alternate:			Phone:			e:	
Caregiver name: Relation:			Fax:				
Local pharmacy: Phone:			Email:				
Insurance plan: Plan ID:			If shipping to pre				er
Please fax a copy of fron	t and back of the insur	ance card(s).					
Clinical Information (P	lease fax all pertiner	nt clinical and lab	information)				
Diagnosis: □ □				Diagr	nosis Date:		
ICD-10							
Prior Therapy	7 No Reason fo	or Discontinuation of	Therany	Approximate Start Date A		Approximat	e End Date
Thor merapy = 103 c	- No Neason is	r Discontinuation of Therapy Approxima		Аррголіпіс	ate Start Date Approxima		ic Life Date
Comorbidities:							
Concomitant Medications:							
Allergies: ☐ NKDA ☐ Oth	ner:						
_		Direct	tions		Quantity		Refill
Prescription		Direct			Quantity	injector	Refill
Prescription	70mg/ml Auto-injector				Quantity 1x 70mg/ml Auto-	-injector	Refill
_	70mg/ml Auto-injector	Direct	onthly				Refill
Prescription	70mg/ml Auto-injector	□ Inject 70mg subq mc	onthly		1x 70mg/ml Auto- 2 x 70mg/ml Auto	o-injectors	Refill
Prescription ☐ Aimovig		Direct ☐ Inject 70mg subq mo	onthly		1x 70mg/ml Auto-	o-injectors	Refill
Prescription	70mg/ml Auto-injector 225mg/1.5 ml PFS	□ Inject 70mg subq mc □ Inject 140mg subq m	onthly		1x 70mg/ml Auto- 2 x 70mg/ml Auto	p-injectors	Refill
Prescription Aimovig		□ Inject 70mg subq mc	onthly		1x 70mg/ml Auto- 2 x 70mg/ml Auto 1x 225mg/1.5ml P	p-injectors	Refill
Prescription ☐ Aimovig		□ Inject 70mg subq mc □ Inject 140mg subq m	nonthly nonthly very 3 months		1x 70mg/ml Auto- 2 x 70mg/ml Auto 1x 225mg/1.5ml P	p-injectors	Refill
Prescription Aimovig Ajovy Dalfampridine ER generic for Ampyra	225mg/1.5 ml PFS 10mg tablets	□ Inject 70mg subq mc □ Inject 140mg subq m □ Inject 225mg subq m □ Inject 675mg subq ec Take one tablet by mo	nonthly nonthly very 3 months	dose	1x 70mg/ml Auto- 2 x 70mg/ml Auto- 1x 225mg/1.5ml P 3 x 225mg/1.5ml F	p-injectors PFS PFS	Refill
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