NEUROLOGY REFERRAL FORM

Date: ______________________________

☐ Current Patient ☐ New Patient

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

Need by date: ______________________ Ship to: ☐ Patient's home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

Patient Information

Patient Name: ______________________________________

Address: ______________________________________

City, State, Zip: ______________________________________

Home Phone: ______________________________________

Cell Phone: ______________________________________

Alternate Phone: ______________________________________

DOB: ______________________ Gender: ☐ M ☐ F

Prescriber Information

Prescriber Name: ______________________________________

Address: ______________________________________

City, State, Zip: ______________________________________

Phone: ______________________________________

Fax: ______________________________________

DEA: ____________________ NPI #: ____________________

Contact Person: ______________________________________

Insurance Information

Primary Insurance: ______________________________ ID#: ____________________ Group: ____________________

Secondary Insurance: ______________________________ ID#: ____________________ Group: ____________________

Prescription Card: ______________ ID#: ______________ BIN#: ________ PCN#: ________ Group: ____________________

Diagnosis & Lab Work (Fill in below or attach lab work)

Primary Diagnosis: ______________ Laboratory Results: LEVF ___________ Date: _________ Platelets: ___________ Date: _________

ANC: ______________ Date: ______________ Bilirubin: ______________ mg/dL Date:__________ Allergies: ____________________

Pregnancy Test: ______________ (+/-) Date: ________________ Concurrent Meds: ______________________________

Expected Date of First/Next Injection: ________________________ Date of Last Injection (if applicable): ____________________

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
Aubagio (teriflunomide)	☐ 7mg ☐ 14mg	☐ Take one 7mg tablet orally once daily ☐ Take one 14mg tablet orally once daily		
Avonex (Interferon beta-1a)	☐ 30mcg PFS ☐ 30mcg syringe	☐ Dose Titration: Week 1 – Inject 7.5mcg IM; Week 2 – Inject 15mcg IM; Week 1- Inject 22.5mcg IM; Week 4+ - Inject 30mcg IM; ☐ Inject 30mcg IM once weekly		
Betaseron	☐ 0.3mg vial kit	☐ Dose Titration: Weeks 1-2 – Inject 0.0625mg/0.25mL; Weeks 3-4 – Inject 0.125mg/0.50mL; Weeks 5-6 – Inject 0.1875mg/0.75mL; Weeks 7+ – Inject 0.25mg/1mL ☐ Inject 0.25mg (1mL) SC every other day		
Copaxone (glatiramer acetate)	☐ 20mg PFS ☐ 40mg PFS	☐ Inject 20mg SC daily ☐ Inject 40mg SC three times per week ☐ Autoject 2		
Dalfampridine	☐ 10mg	☐ 10mg PO once every 12 hours		
Extavia (Interferon beta – 1b)	☐ 0.3mg vial	☐ Dose Titration: Weeks 1-2 – Inject 0.0625mg/0.25mL; Weeks 3-4 – Inject 0.125mg/0.50mL; Weeks 5-6 – Inject 0.1875mg/0.75mL; Weeks 7+ – Inject 0.25mg/1mL ☐ Inject 0.25mg/1mL SC every other day		
Gilenya	☐ 0.5mg	☐ 0.5 mg PO once daily		
Mitoxantrone HCL	☐ 20 mg MDV ☐ 25mg MDV ☐ 30mg MDV	☐ Dilute and administer 12mg/mL as IV		

Flush Protocol

☐ DSW 5-10mL before and after infusion followed by 3-5mL of Heparin 100u/mL

☐ NaCl 0.9% 5-10mL before and after infusion followed by 3-5mL of Heparin 100u/mL

☐ Other: ____

Pre-Medications & Other Meds: ☐ Infusion supplies as per protocol ☐ Acetaminophen ___________ mg ☐ Epipen

Prior to Infusion: ☐ Diphenhydramine __________ mg ☐ PO ☐ IVP ☐ Solu-medrol ☐ IV ☐ IVP

Prescriber Signature: ____________________________________ DAW (Dispense as Written) Date: ____________________

If Century Specialty Script is the patient's choice, please Call-In, Fax or Mail prescriptions to:
Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353

NEUROLOGY REFERRAL FORM

Date: ______________________________

☐ Current Patient ☐ New Patient

Century Specialty Script

Fax Referral To: 877-521-5353

Phone: 800-521-3949

CENTURY SPECIALTY SCRIPT

Need by date: ________________________ Ship to: ☐ Patient's home ☐ Prescriber 1st Order Only ☐ Prescriber All Orders

Patient Information

Patient Name: ____
Address: ____
City, State, Zip: ____
Home Phone: ____
Cell Phone: ____
Alternate Phone: ____
DOB: ______________________ Gender: ☐ M ☐ F

Prescriber Information

Prescriber Name: ____
Address: ____
City, State, Zip: ____
Phone: ____
Fax: ____
DEA: ______________________ NPI #: ______________________
Contact Person: ____

Insurance Information

Primary Insurance: ______________________________ ID#: ____________________ Group: ____________________
Secondary Insurance: ______________________________ ID#: ____________________ Group: ____________________
Prescription Card: ______________ ID#: ______________ BIN#: ________ PCN#: ________ Group: ____________________

Diagnosis & Lab Work (Fill in below or attach lab work)

Primary Diagnosis: ______________ Laboratory Results: LEVF ____________ Date: __________ Platelets: ___________ Date: _________
ANC: _______________ Date: ______________ Bilirubin: ______________ mg/dL Date:__________ Allergies: ____________________
Pregnancy Test: ________________ (+/-) Date: __________________ Concurrent Meds: ______________________________
Expected Date of First/Next Injection: __________________________ Date of Last Injection (if applicable): ______________________

Prescription Information

Medication	Dose Strength	Directions	Qty	Refills
Ocrevus IV	☐ 300mg ☐ 600mg	☐ **Loading Dose:** 300mg on Day 1, then 300mg 2 weeks after ☐ **Maintenance Dose:** 600mg once every 6 months, after initial dose		
Plegridy	☐ **Pen & Prefilled Syringe:** 63mcg/0.5mL & 94mcg/0.5mL ☐ **Pen & Prefilled Syringe:** 125mcg/0.5mL	☐ **Loading Dose:** Inject 63mcg SQ on day 1 and 94mcg SQ on Day 15 ☐ **Maintenance Dose:** Inject 125mcg SQ once every 14 days starting on Day 2		
Rebif	☐ Target dose 44mcg ☐ Target dose 22mcg	☐ **Initial 44mcg:** 8.8mcg (20% of target dose) 3 times weekly for 2 weeks ☐ **Titration 44mcg:** 22mcg (50% of target dose) 3 times weekly for 2 weeks ☐ **Initial 22mcg:** 4.4mcg (20% of target dose) 3 times weekly for 2 weeks ☐ **Titration 22mcg:** 11mcg (50% of target dose) 3 times weekly for 2 weeks		
Tecfidera (Dimethyl Fumarate)	☐ 120mg ☐ 240mg	☐ **Loading Dose:** 120mg PO BID for 7 days ☐ **Maintenance Dose:** 240mg BID		
Vumerity	☐ 231mg	☐ **Loading Dose:** 231mg PO BID for 7 days ☐ **Maintenance Dose:** 462mg PO BID		
Vyepti	☐ 100mg/mL	☐ 100mg infused over 30 minutes once every 3 months ☐ 300mg infused over 30 minutes once every 3 months		
Xembify	☐ ______________________	☐ ______________________________________	☐	
Zeposia	☐ **7 Day Starter Pack:** 0.23mg (4 capsules) 0.46mg (3 capsules) ☐ 0.92mg capsules	☐ **Loading Dose:** 0.23mg PO once daily on Days 1-4, then 0.46mg PO once daily on Days 5-7 ☐ **Maintenance Dose:** 0.92mg PO once daily starting on Day 8		

Flush Protocol

☐ DSW 5-10mL before and after infusion followed by 3-5mL of Heparin 100u/mL
☐ NaCl 0.9% 5-10mL before and after infusion followed by 3-5mL of Heparin 100u/mL
☐ Other: ____

Pre-Medications & Other Meds: ☐ Infusion supplies as per protocol ☐ Acetaminophen ___________ mg ☐ Epipen
Prior to Infusion: ☐ Diphenhydramine __________ mg ☐ PO ☐ IVP ☐ Solu-medrol ☐ IV ☐ IVP

Prescriber Signature: ____________________________________ **DAW (Dispense as Written) Date:** ______________________

If Century Specialty Script is the patient's choice, please Call-In, Fax or Mail prescriptions to:
Century Specialty Script, 6 Fisher Avenue, Tuckahoe, NY, 10707 • Phone (800) 521-3949, Fax (877) 521-5353