FACTOR ONE SOURCE FAST PHARMACY

FAX 1-844-504-3278
PHONE 1-877-327-8881
www.FASTACCESSRX.com

NEUROLOGY FORM

PATIENT INFORMATION:

Patient Name:_____
Date of Birth:_____ Male: ☐ Female: ☐
Address:_____
City/State/Zip:_____
Tel:_____Alt Tel:_____
SS#:_____Wt:_____Ht:_____
NKDA☐ Allergy:_____
Emergency Contact:_____

INSURANCE INFORMATION:

Primary Pharmacy Insurance_____
Member Name:_____
Member ID:_____
Rx Group #:_____
BIN#_____PCN#_____
Customer Service #:_____

*Please attach a copy of the front and back of the patient's insurance card, if available.******

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis and ICD10:_____

History: Has the patient been treated for this condition previously? ☐ Yes ☐ No
Is the patient currently on therapy? ☐ Yes ☐ No
What other medications has the patient tried and failed? _____

PRESCRIBER INFORMATION:

Prescriber_Name:_____Specialty:_____
Address:_____City/State/Zip:_____
Contact_Name:_____ Phone#:_____Fax#:_____
NPI#:_____ DEA #:_____UPIN #:_____

By signing this form and using our services, you are authorizing F.A.S.T. to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.

Prescriber Printed Name:_____ Date:_____
Prescriber Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

_____ _____
Substitution Allowed *Dispense as Written*

PRESCRIPTION:

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Avonex®	☐ 30mcg PFS	☐ Inject 30mcg IM once weekly	1 month supply	_____
	☐ 30mcg vial	☐ Other:_____	1 month supply	_____
☐ AIMOVIG®	☐ 70mg	☐ Inject 70mg SubQ once monthly		
	☐ 140mg	☐ Inject 140mg SubQ once monthly (2 70mg injections consecutively)	1 month supply	_____
☐ Betaseron®	☐ 0.3 mg PFS	☐ Initial: Week 1&2: 0.25ml (0.0625mg), Week 3&4: 0.5ml (0.125mg) Week 5&6: 0.075ml (0.1875mg), Week 7+ 1ml (0.25mg) SubQ every other day	1 month supply	_____
		☐ Maintenance: Inject 1ml (0.25mg) SubQ every other day		
☐ Copaxone®	20mg PFS	☐ Inject 20mg SubQ every day	1 month supply	_____
☐ Extavia®	0.3mg Kit	☐ Inject 0.25mg SubQ every other day	1 month supply	_____
☐ Gilenya™	0.5mg cap	☐ Take 1 capsule by mouth once daily	1 month supply	_____
☐ Glatopa™	20mg PFS	☐ Inject 20mg SubQ every day	1 month supply	_____
☐ Rebif®	☐ Titration Pack	☐ Initial: Week 1&2: 0.2ml (8.8mg), week 3&4: 0.5ml (22mcg) SubQ three times weekly	1 month supply	_____
	☐ 22mcg PFS	☐ Maintenance: Inject 0.5ml (22mcg) SubQ three times weekly		
	☐ 44mcg PFS	☐ Maintenance: Inject 0.5ml (44mcg) SubQ three times weekly		
		☐ Other:_____ Inject		
☐ Epipen®	2 pack	☐ 1 pen into thigh in case of anaphylaxis	1 box of 2	_____
☐ Epipen® Jr				
☐ Other	_____	_____	_____	_____