echocare
SPECIALTY PHARMACY
"Your partner in patient care"

260 Broadway
Brooklyn, NY 11211
Phone: 718-782-0101
Fax: 718-782-2626
www.EchoDrugs.net

NEUROLOGY REFERRAL FORM

Fax prescription to: 718-782-2626

Faxed prescriptions can only be accepted from prescribing practitioners

Date Needed By _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ SS# _____ DOB _____

☐ Male ☐ Female Height_____ Weight _____ Age _____

Allergies _____ ☐ NKDA

INSURANCE INFORMATION

Please attach front and back of all insurance and prescription drug cards

PRESCRIBER INFORMATION

Name _____

NPI _____ State License# _____

Group/Hospital _____

Address _____

City, State, Zip _____

Main Phone _____ Fax _____

Contact Person _____ Phone _____

CLINICAL EVALUATION

LABS *Please include lab reports, clinical data, and current vital signs.* ***Fax to: 718-782-2626***

Latest copy of CBC with differential Labs attached? ☐ Yes ☐ No

Reason if not attached _____

Lab Date _____ Height _____ Weight _____ BSA _____

CONCURRENT MEDICATIONS *Please list concurrent medications below*

Is patient pregnant? ☐ Yes ☐ No

DIAGNOSIS *Please select below* Diagnosis date:

- ☐ D69.3 Immune Thrombocytopenic Purpura
- ☐ G25.82 Stiff-man Sydrome
- ☐ G35 Multiple Sclerosis
- ☐ G60.3 Idiopathic Progressive Neuropathy
- ☐ G61.0 Gullain-Barre Syndrome
- ☐ G61.81 Chronic Inflammatory Demyelinating Polyneuritis
- ☐ G62.89 Multifocal Motor Neuropathy
- ☐ G70.00 Myasthenia Gravis without (acute) exacerbation
- ☐ G70.01 Mysthenia Gravis with (acute) exacerbation
- ☐ L10.0 Pemphigus Vulgaris
- ☐ M33.20 Polymyositis organ involvement unspecified
- ☐ M33.90 Dermatopolymyositis organ involvement unspecified

☐ Other _____

PREVIOUS TREATMENTS *Please list previous treatments and therapies below*

Medication/Therapy	Outcome/Reason for discontinuation or failure

PRESCRIPTION INFORMATION

MEDICATION	DOSAGE & DIRECTIONS/AUTHORIZATION # (if applicable)	QUANTITY/DURATION	REFILLS
☐ AIMOVIG (erenumab-aooe)			
☐ AJOVY (fremanezumab-vfrm)			
☐ AMPYRA (dalfampridine)			
☐ AUBAGIO (teriflunomide)			
☐ AUSTEDO (deutetrabenazine)			
☐ AVONEX (interferon beta-1a)			
☐ BETASERON (interferon beta-1b)			
☐ BOTOX (onabotulinumtoxinA)			
☐ COPAXONE (glatiramer acetate injection)			
☐ Dalfampridine			
☐ Dimethyl fumerate			
☐ DYSPORT (abobotulinumtoxinA)			
☐ EMGALITY (galcanezumab-gnlm)			
☐ EXTAVIA (interferon beta-1b)			
☐ GILENYA (fingolimod)			
☐ Glatiramer			
☐ GLATOPA (glatiramer acetate injection)			
☐ OCREVUS (ocrelizumab)			
☐ PLEGRIDY (peginterferon beta-1a)			
☐ TECFIDERA (dimethyl fumarate)			
☐ Tetrabenazine			
☐ XENAZINE (tetrabenazine)			
☐ XEOMIN (incobotulinumtoxinA)			

By signing this form and utilizing our services, you are authorizing Echo Care Specialty Pharmacy and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature _____ ☐ DAW Date _____

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