

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never
Please fax a copy of front and back of the insurance card(s).	

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	1x 70mg/ml Auto-injector
		<input type="checkbox"/> Inject 140mg subq monthly	2 x 70mg/ml Auto-injectors
<input type="checkbox"/> Ajovy	225mg/1.5 mL PFS	<input type="checkbox"/> Inject 225mg subq monthly	1x 225mg/1.5ml PFS
		<input type="checkbox"/> Inject 675mg subq every 3 months	3 x 225mg/1.5ml PFS
<input type="checkbox"/> Dalfampridine ER generic for Ampyra	10mg tablets	Take one tablet by mouth every 12 hours	60 tablets
<input type="checkbox"/> Engality	120mg/ml Auto-injector	<input type="checkbox"/> Initial: Inject 240mg subq as a single loading dose	2 x 120mg/ml Auto-injector
		<input type="checkbox"/> Maintenance: 120mg subq monthly	1 x 120mg/ml Auto-injector
<input type="checkbox"/> Nuedexta	20-10mg capsules	<input type="checkbox"/> Take one capsule by mouth daily for 7 days, then increase to one capsule by mouth twice daily	60 capsules
		<input type="checkbox"/> Take one capsule by mouth twice daily	
<input type="checkbox"/> Nuplazid	<input type="checkbox"/> 34mg capsules	Take one capsule by mouth daily	30 capsules
	<input type="checkbox"/> 10mg tablets	Take one tablet by mouth daily	30 tablets
<input type="checkbox"/> Vyepti	100 mg/mL vial	<input type="checkbox"/> Infuse 100mg IV every 3 months	90 day supply
		<input type="checkbox"/> Infuse 300mg IV every 3 months	

Injection Training Provided by: Physican Office CoxHealth at Home Training not needed

Ship to: Patient Physican Office CoxHealth at Home

Prescriber's Signature: _____ Date: _____

I authorize CoxHealth at Home, 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 CoxHealth at Home

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