UNIVERSAL
• SPECIALTY PHARMACY •

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www.rxuniversal.com

Neuromuscular Disorder Referral Form

☐ **Urgent/Stat** ☐ **Standard**

Prescriber

Prescriber Information

Prescriber Name:			☐MD ☐PA ☐NP
NPI:	DEA:	Office Contact:	
Address:			
City:	State:	Zip:	Phone #: / Fax #:

Patient

Patient Information - Fax A Copy Of The Front And Back Of All Insurance Cards

First Name:	MI:	Last Name:	
DOB:	Sex: ☐M ☐F	Last 4 Digits SSN :	Interpreter: ☐Y ☐N Specify:
Address:			
City:	State:	Zip:	Primary #: / Alternate #:
Emergency Contact:	Phone #:	Contact Preference: ☐AM ☐Noon ☐PM	

Clinical

Clinical Information - Please Send Progress Notes, Lab Reports And Any Other Supporting Documents

Primary ICD10:	Secondary ICD10:	Diagnosis Date: / /
Weight: ☐lb/ ☐kg	Height: ☐in/ ☐cm	Allergies:
Current Medications:		
Prior Therapies:		Diagnosis Date: / /
Continuity of Care: / /		

Prescription

Prescription Information

Dose Start Date: / / ☐New Prescription ☐Refill Prescription ☐New to Therapy ☐Restarting Therapy

Deliver to: ☐Patient's Home ☐Prescriber's Office ☐Other

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Botox®	☐100 Unit Vial ☐200 Unit Vial	☐Inject ___ units IM into ___ every ___ (weeks/months)		
☐ Dysport®	☐300 Unit Vial ☐500 Unit Vial	☐Inject ___ units IM into ___ every ___ (weeks/months)		
☐ Myobloc®	☐2,500 Unit Vial ☐5,000 Unit Vial ☐10,000 Unit Vial	☐Inject ___ units IM into ___ every ___ (weeks/months)		

Other:

To be given by prescriber in office any unused portion to be discarded

☐ Dispense ancillary supplies, syringes and medical equipment necessary to administer medication.

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

Sign

Prescriber Signature and Date (Required to validate prescription)

Physician Signature:	Date: / /