



Melissa Przeklasa Auth, M.D.
30131 Town Center Drive Suite # 195
Laguna Niguel, CA 92677
Office: (949) 495-6100
Fax: (949) 354-0612
occhildneurology.com

Medication Policy

Effective September 1, 2016

Dr. Przeklasa will provide you with enough medication until your next follow-up appointment. Your child will need to be seen in the office for follow-up visits until he or she is stable on the medication. Frequent follow-ups are necessary in the beginning stages to assess for any side effects and to assist with adjusting the medication to find the proper dosage. Once your child is stable on medication, office visits will typically be spaced out to every 3-4 months.

With regard to stimulant medications, they are strictly controlled by the DEA. The original prescription must be hand carried to the pharmacy or sent electronically under controlled procedures in order to be filled. These medications can only be written for a 30-day supply without refills.

We currently participate in the Surescripts system, which is a Pharmacy Benefit Manager. This allows for the electronic prescribing of medications, which provides a convenience to patients and physician and also reduces medication errors. An additional portion of this service allows for the electronic receiving of prescription benefits and medication history such as past prescriptions and dosages filled from other pharmacies. This provides your physician with an up-to-date medication profile. By signing below, you give Dr. Przeklasa Auth permission to E-Prescribe and access your information to receive this electronically, which will become a part of your electronic medical record.

Any medication refills, changes, or lost prescriptions requested, in between visits, will be subject to a \$20 fee.

If your insurance requires a prior authorization for medication, it can take up to 7 business days. All prior authorizations are performed on Mondays and Thursdays. Please be sure that your pharmacy sends us the required documentation, we cannot proceed with a prior authorization without the appropriate pharmacy codes.

Thank you for your cooperation.

Patient Name: _____

Parent Name: _____ Date: _____

Parent Signature: _____

Name, address and phone number of your primary pharmacy:
