MS Oral Agents

phone: 1.877.829.3137
fax: 1.417.869.0277

Patient Information

patient: ______________________________ male / female DOB: __________ SS#: __________
last name, first name

address: ______________________________
street city state zip

primary phone number: __________ cell alternate phone number: __________ cell

caregiver: __________ allergies: __________ NKDA

comorbidities: __________ height: ______ weight: ______ lbs / kg date: __________

Clinical Information

Primary ICD-10 Code: G35 **Secondary ICD-10 Code:** __________ **Date of first demyelinating event:** __________

Type: Clinically isolated syndrome Relapsing-remitting Secondary-progressive Primary-progressive Progressive-relapsing

Please provide clinical rationale for prescribing this agent (if not preferred formulary agent):

Prior therapies **Reason for discontinuation**

Prescription	strength	directions	quantity	refills
Ampyra®	**To order Ampyra® please see the Acorda form at ampyra-hcp.com/local/files/acorda_SRF_V35.pdf** **phone: 888.881.1918 fax: 888.883.3053**			
Aubagio®	7 mg 14 mg	Take one tablet by mouth once daily Other: __________	1 box (28 tablets)	
Gilenya®	0.5 mg	Take one capsule by mouth once daily Other: __________	1 box (30 capsules)	
Tecfidera® 30-Day Starter Pack		1 capsule (120 mg) orally twice a day for 7 days, then 1 capsule (240 mg) twice a day thereafter	Starter pack = 14 x 120 mg capsules and 46 x 240 mg capsules	0
Tecfidera®	240 mg	1 capsule orally twice daily Other: __________	60 capsules	

Prescriber + Shipping Information

prescriber (print): ______________________________ office contact: __________

ship to: patient office alternate __________
shipping address: street city state zip

office address: ______________________________
(street, suite, city, state, zip)

phone: __________ fax: __________ NPI: __________ DEA: __________

prescriber's signature: ______________________________ date: __________

I authorize Dan's Discount Drug Mart and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Insurance Information: please fax copy of insurance card (front + back)

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