Multiple Sclerosis Oral Agents

DIPLOMAT®

Phone: 877.977.9118
Fax: 866.208.4142
Insert Sales Contact Name (if known)

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____
Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____☐cm ☐in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis: ☐ G35 (Multiple Sclerosis) ☐ _____ Diagnosis Date: _____

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

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Prescription		Quantity	Refill
☐ **Ampyra®** (dalfampridine)	To order Ampyra® please see the Acorda form at ampyra-hcp.com/local/files/acorda-service-request-form.pdf Phone: 888-881-1918 Fax: 888-883-3053		
☐ **Aubagio®** (teriflunomide)	☐ Take 7 mg by mouth once daily ☐ Take 14 mg by mouth once daily	☐ 28 x 7 mg tablets ☐ 28 x 14 mg tablets	_____
☐ **Gilenya®** (fingolimod)	☐ Take 0.5 mg by mouth once daily	☐ 30 x 0.5 mg capsules	_____
☐ **Tecfidera®** (dimethyl fumarate)	☐ Take 120 mg by mouth twice daily for 7 days, then 240 mg by mouth twice daily thereafter.	☐ 30-day starter pack	0
	☐ Take 240 mg by mouth twice daily ☐ _____	☐ 60 x 240 mg capsules ☐ _____	_____

For patients requiring immune globulin therapy, please fill out the respective form: IVIg or SCIg.

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Stamp signature not allowed, physician signature required.

Prescriber's Signature:_____ Date: _____

I authorize Diplomat Pharmacy, Inc. 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 Diplomat Pharmacy, Inc.

Reset Form