

Multiple Sclerosis Oral Agents



Phone: 877.977.9118

Fax: 866.208.4142

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____ Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> 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 name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never

Clinical Information (Please fax all pertinent clinical and lab information)			
Diagnosis: <input type="checkbox"/> G35 (Multiple Sclerosis) <input type="checkbox"/> _____ Diagnosis Date: _____ Type: <input type="checkbox"/> Clinically isolated syndrome <input type="checkbox"/> Relapsing-remitting <input type="checkbox"/> Secondary-progressive <input type="checkbox"/> Primary-progressive <input type="checkbox"/> Progressive-relapsing			
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	Quantity	Refill
<input type="checkbox"/> 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	
<input type="checkbox"/> Aubagio® (teriflunomide)	<input type="checkbox"/> Take 7 mg by mouth once daily <input type="checkbox"/> Take 14 mg by mouth once daily	<input type="checkbox"/> 28 x 7 mg tablets <input type="checkbox"/> 28 x 14 mg tablets _____
<input type="checkbox"/> Gilenya® (fingolimod)	<input type="checkbox"/> Take 0.5 mg by mouth once daily	<input type="checkbox"/> 30 x 0.5 mg capsules _____
<input type="checkbox"/> Tecfidera® (dimethyl fumarate)	<input type="checkbox"/> Take 120 mg by mouth twice daily for 7 days, then 240 mg by mouth twice daily thereafter.	<input type="checkbox"/> 30-day starter pack 0
	<input type="checkbox"/> Take 240 mg by mouth twice daily <input type="checkbox"/> _____	<input type="checkbox"/> 60 x 240 mg capsules <input type="checkbox"/> _____

For patients requiring immune globulin therapy, please fill out the respective form: [IVlg](#) or [SClg](#).

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.

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