



Multiple Sclerosis Oral Agents

PHONE: 1-800-637-9201
FAX: 1-417-269-0692

Patient Information	Prescriber + Shipping Information
Patient name: _____ DOB: _____	Prescriber name: _____
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male SSN: _____	NPI: _____
Language: _____ Wt: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs Ht: _____ <input type="checkbox"/> cm <input type="checkbox"/> in	Address: _____
Address: _____	Apt/Suite: _____ City: _____ State: _____ Zip: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____	Contact: _____
Phone: _____ Alternate: _____	Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____	Fax: _____
Local pharmacy: _____ Phone: _____	Email: _____
Insurance plan: _____ Plan ID: _____	If shipping to prescriber: <input type="checkbox"/> First Fill <input type="checkbox"/> Always <input type="checkbox"/> Never
Please fax a copy of front and back of the insurance card(s).	

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	28 x 7 mg tablets
	<input type="checkbox"/> Take 14 mg by mouth once daily	28 x 14 mg tablets
<input type="checkbox"/> Gilenya [®] (fingolimod)	Take 0.5 mg by mouth once daily	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.	30-day starter pack
	<input type="checkbox"/> Take 240 mg by mouth twice daily	60 x 240 mg capsules
	<input type="checkbox"/> _____	_____

For patients requiring immune globulin therapy, please fill out the respective form (IVIG or Subq IG)

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: _____

Substitution Permitted Dispense as Written

I authorize Home Parenteral Services, 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 Home Parenteral Services.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 1 800-637-9201 to obtain instructions as to the proper destruction of the transmitted material. Thank you.