ameripharma SPECIALTY CARE

Multiple Sclerosis Oral Agents

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient Information

Patient Name: ______ DOB: ______ Sex: ☐ Male ☐ Female SSN: ______ Wt (kg/lbs): ______ Ht (cm/in): ______

Address: ______ Phone: ______ Alternate: ______

Caregiver Name: ______ Relation to Patient: ______ Phone: ______

Insurance Plan: ______ Plan ID: ______ BIN #: ______ PCN #: ______ GRP #: ______

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: ______ DEA: ______ NPI: ______

Address: ______

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	Start Date	End Date

Comorbidities: ______

Concomitant Medications: ______

Allergies: ☐ NKDA ☐ Other: ______

Prescription	Directions, Quantity, Form		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 once daily by mouth	☐ 28 x 7 mg tablets	
	☐ Take 14 mg once daily by mouth	☐ 28 x 14 mg tablets	
☐ **Gilenya®** (fingolimod)	☐ Take 0.5 mg once daily by mouth	☐ 30 x 0.5 mg capsules	
☐ **Tecfidera®** (dimethyl fumarate)	☐ Take 120 mg twice daily by mouth for 7 days, then 240 mg twice daily by mouth thereafter.	☐ 30-day starter pack	0
	☐ Take 240 mg twice daily by mouth	☐ 60 x 240 mg capsules	
	☐ ______	☐ ______	

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

Prescriber's Signature: ______ Date: ______

I authorize AmeriPharma 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 AmeriPharma.

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