SPECIALTY CARE SOLUTIONS

Multiple Sclerosis Rx Referral Form

Oral Agents

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E-Scripts NCPDP#3199367 NPI#1881932093

Date Medication Needed: ______ **Ship To:** ☐ Patient's Home ☐ Prescriber's Office ☐ Or Pick-up from Pharmacy

Injection needed by pharmacy? ☐ Yes ☐ No

1: Patient Information

Patient Name: ______ **Birthdate:** ______ **Sex:** Male Female **Height:** ______ **Weight:** ______ lbs. kg.

Soc. Sec. #: ______ **Preferred Phone:** ______ **Known Allergies:** ______

Address: ______ **City:** ______ **State:** ______ **Zip:** ______

Alternate Caregiver Name: ______ **Preferred Phone:** ______

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: 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: ______

3: Prescriber Information

Prescriber Name: ______ **DEA#:** ______ **NPI#:** ______ **Tax ID#:** ______

Address: ______ **Phone:** (____) ____ - ____ **Fax:** (____) ____ - ____

City: ______ **State:** ______ **Zip:** ______ **Key Contact:** ______ **Phone:** (____) ____ - ____

4: Prescription Information

Medication	Directions	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 ☐ ______	______

Patient Support Programs: Please sign and date below to enroll in the pharmaceutical company assisted patient support program

Patient Signature: ______ Date: ______

I authorize Park Ave. Pharmacy and its representatives to act as an agent to execute Prior authorization process.

Prescriber Signature: Prescriber, please sign and date below

Substitution Permissable ______ Date ______ Dispense as written ______ Date ______

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.