

# Multiple Sclerosis Oral Agents



## 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Comorbidities: \_\_\_\_\_

Concomitant Medications: \_\_\_\_\_

Allergies:  NKDA  Other: \_\_\_\_\_

		Quantity	Refill
<b>Ampyra®</b> (dalfampridine)	Take 10 mg by mouth twice a day, approximately 12 hours apart	60 x 10 mg tablets	_____
<b>Aubagio®</b> (teriflunomide)	Take 7 mg by mouth once daily	28 x 7 mg tablet blister card 30 x 7 mg tablet bottle	_____
	Take 14 mg by mouth once daily	28 x 14 mg tablet blister card 30 x 14 mg tablet bottle	_____
<b>Gilenya®</b> (fingolimod)	Adults and pediatric patients $\geq$ 10 years of age, weighing at least 40 kg: Take 0.5 mg by mouth once daily	30 x 0.5 mg capsules	_____
	Pediatric patients $\geq$ 10 years of age, weighing $\leq$ 40 kg: Take 0.25 mg by mouth once daily	30 x 0.25 mg capsules	_____
<b>Mavenclad®</b> (cladribine)	To prescribe Mavenclad®, please visit the Mavenclad® Form <a href="#">here</a>	_____	_____
<b>Mayzent®</b> (siponimod)	To prescribe Mayzent®, please visit the Mayzent® Start Form <a href="#">here</a>	_____	_____
<b>Tecfidera®</b> (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.

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