



Patient Information

patient: _____ male
last name, first name female DOB: _____ SS#: _____

address: _____
street city state zip

primary phone number: _____ cell alternate phone number: _____ cell

caregiver: _____ allergies: _____ NKDA

comorbidities: _____ height: _____ weight: _____ lbs
kg date: _____

Clinical Information

Primary ICD-9 Code: 340 Secondary ICD-9 Code: _____ Date of first demyelinating event: _____

Type: Clinically isolated syndrome Relapsing-remitting Secondary-progressive Primary-progressive Progressive-relapsing

Please provide clinical rationale for prescribing this agent (if not preferred formulary agent):

Prior therapies	Reason for discontinuation

Prescription	strength	directions	quantity	refills
Ampyra®	To order Ampyra® please see the Acorda form at ampyra-hcp.com/local/files/acorda_SRF_V35.pdf phone: 888.881.1918 fax: 888.883.3053			
Aubagio®	7 mg 14 mg	Take one tablet by mouth once daily Other: _____	1 box (28 tablets)	
Gilenya®	0.5 mg	Take one capsule by mouth once daily Other: _____	1 box (28 capsules) 1 bottle (30 capsules)	
Tecfidera® 30-Day Starter Pack		1 capsule (120 mg) orally twice a day for 7 days, then 1 capsule (240 mg) twice a day thereafter	Starter pack = 14 x 120 mg capsules and 46 x 240 mg capsules	0
Tecfidera®	240 mg	1 capsule orally twice daily Other: _____	60 capsules	

Prescriber + Shipping Information

prescriber (print): _____ office contact: _____

ship to: patient office alternate
shipping address: street city state zip

office address: _____
(street, suite, city, state, zip)

phone: _____ fax: _____ NPI: _____ DEA: _____

prescriber's signature: _____ date: _____

I authorize Rx International Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Insurance Information: please fax copy of insurance card (front + back)

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