MS Oral Agents

Employee Owned Thrifty White PHARMACY Specialty Services
toll-free phone 855.611.3399
toll-free fax 855.423.8300

Patient Information

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

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-10 Code: G35 Secondary ICD-10 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 (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 Thrifty White Specialty Pharmacy 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 Thrifty White Specialty Pharmacy.

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