

# MS Oral Agents



toll-free phone 855.611.3399  
toll-free fax 855.423.8300

## 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-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 <a href="http://ampyra-hcp.com/local/files/acorda_SRF_V35.pdf">ampyra-hcp.com/local/files/acorda_SRF_V35.pdf</a> 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)

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[www.thriftlywhite.com](http://www.thriftlywhite.com)

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