DolphinHealth Rx
Committed to Helping People Get Well

Multiple Sclerosis Oral Medication Form

Toll Free: 844-436-5744
Local Phone: 510-900-3131
Fax: 844-329-6979

1 PATIENT INFORMATION

Written Date:

Ship To:
- ☐ Patient (All Fills)
- ☐ Provider (1st Fill Only)
- ☐ Provider (All Fills)
- ☐ ___________

Patient Name:
Date of Birth:
SSN:
Address:
City, State, Zip Code:
Phone:
Email Address:
Preferred language:
Contact Person:

2 INSURANCE INFORMATION

PLEASE FAX A COPY (FRONT AND BACK) OF PATIENT'S CURRENT ACTIVE INSURANCE AND ID CARDS. FOR PATIENTS WITH BOTH MEDICARE AND MEDI-CAL, PLEASE FAX IN COPIES FOR BOTH.

3 SPECIAL INSTRUCTION

Training:
- ☐ Pharmacy will coordinate training for patient
- ☐ Provider will provide training
- ☐ Training not necessary
- ☐ Enroll patient In manufacturer support program

Delivery: ___________________________

4 CLINICAL INFORMATION

PLEASE FAX COPIES OF RECENT CHART NOTES, LABS, EVIDENCE OF DIAGNOSIS, AND CURRENT MEDICATION LIST.

5 DIAGNOSIS AND CLINICAL INFORMATION

Diagnosis (ICD-9 or ICD-10)

Date of Diagnosis ___________________

☐ G35 Multiple Sclerosis ☐ Other ICD-10 Code and Description ___________________

Has patient had positive TB test? ☐YES ☐NO If yes, date of last chest x-ray: ___________

Height: ___________ Weight: ___________ Allergies: ___________

Is the patient currently on therapy? ☐ YES ☐ NO If YES, what medication and when did they start? ___________

Number of relapses in the past year ___________

Date of last MRI ___________ MRI changes ☐YES ☐ NO

Previously Tried/Failed Medications- include dosage and frequency	Date of Trial	Reason for Discontinuation

6 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Aubagio® teriflunomide	☐ 7mg ☐ 14mg	☐ Take 1 (7mg) tablet orally daily ☐ Take 1 (14mg) tablet orally daily	☐ 28 tablets (1 bottle) ☐ 84 tablets (3 bottles)	
☐ Gilenya® fingolimod	0.5mg	Take 1 (0.5mg) capsule orally daily.	☐ 30 capsules ☐ 90 capsules	
☐ Tecfidera® dimethyl fumarate	☐ Starter Pack	☐ Starter PackTitration: 1x120mg cap po BID x7days, then 1x240mg cap BID	☐ Starter Pack (14 caps x 120mg & 46 caps of 240mg): 30- day supply	0 (not refillable)
	☐ 120mg capsules ☐ 240mg capsules	☐ 1x240mg cap po BID ☐ Other___________	☐ 120mg - 7 day supply - Other ________ ☐ 240mg - 30 day supply - 90 day supply - Other ________	
☐ Ampyra® dalfampridine	10mg	☐ Take 1 tablet twice daily ☐ Other___________	☐ 60 tablets ☐ 180 tablets	

7 PROVIDER AUTHORIZATION & INFORMATION

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to Dolphin Health to act as the prescriber's agent to begin and To execute the prior authorization process and to help the patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Name: ___________ Address: ___________

DEA: NPI: City, State, ZIP Code: ___________

Phone: Fax: Contact Person: ___________

Date: ___________ Provider Signature: ___________

19/10/2016