CoxHealth at Home

Multiple Sclerosis Oral Agents

PHONE: 1-855-419-4663
FAX: 1-417-269-0692

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 ❑ Yes ❑ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____

Concomitant Medications: _____

Allergies: ❑ NKDA ❑ Other: _____

Prescription		Quantity	Refill
❑ **Ampyra®** (dalfampridine)	Take 10mg by mouth twice daily, approx 12 hours apart	60 x 10mg tablets	_____
❑ **Aubagio®** (teriflunomide)	❑ Take 7 mg by mouth once daily	28 x 7 mg tablets	_____
	❑ Take 14 mg by mouth once daily	28 x 14 mg tablets	_____
❑ **Gilenya®** (fingolimod)	Take 0.5 mg by mouth once daily	30 x 0.5 mg capsules	_____
❑ **Tecfidera®** (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	_____
❑ **Vumerity** (diroximel fumarate)	❑ Take 231mg (one-231 mg capsule) by mouth twice daily for 7 days, then 462mg (two-231mg capsules) twice daily thereafter.	106 x 231 mg capsules starter dose bottle	0
	❑ Take 462mg (two-231mg capsules) by mouth twice daily	120 x 231mg capsules	_____
❑ **Zeposia** (ozanimod)	❑ Take 0.23 mg by mouth once daily on days 1-4, 0.46mg once daily on days 5-7, then 0.92mg once daily thereafter	Starter Kit (7-day Starter Pack and 30 x 0.92mg capsules	0
	❑ Take 0.92mg by mouth once daily	30 x 0.92mg capsules	_____
For patients requiring immune globulin therapy, please fill out the respective form (IVIG or SQIG)			
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 CoxHealth at Home 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 CoxHealth at Home.

CoxHealth