SPS Specialty Pharmacy Services, Inc.

Contact for Office: 787-704-2025 /2028
FAX: 787-704-2027

Multiple Sclerosis Oral Agents Enrollment/Prescription Form

Patient Information

Date:_____ Patient SS#:_____ ☐ Male ☐ Female
Patient's First Name:_____ Patient's Last Name:_____
Address:_____ City:_____ State:_____ Zip:_____
Best Phone Number:_____ Alternate Phone Number:_____
DOB:_____ Caregiver:_____ Allergies:_____

Prescription Information

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARD (FRONT & BACK)

ICD-9 Code: CM 340 Secondary ICD-9 Code:_____ Date of first demyelinating event:_____
Type: ☐ Relapsing-remitting ☐ Secondary-progressive with relapses ☐ Primary-progressive
☐ Secondary-progressive without relapses ☐ Clinically Isolated Syndrome (CIS) ☐ Progressive-relapsing

Please provide clinical rationale for prescribing this agent (if not preferred formulary agent):
Prior therapies:_____ Reason for discontinuation:_____
Other:_____

Date Shipment Needed:_____ **Ship to:** ☐ **Patient** ☐ **Physician/Clinic**

Medication	Strength	Directions	Quantity	Refills
☐ **Gilenya**	0.5mg	☐ Take one capsule by mouth once daily ☐ Other:_____	1 BOX (28 capsules)	_____
☐ **Aubagio**	☐ 14mg ☐ 7mg	☐ Take one tablet by mouth once daily ☐ Other:_____	1 BOX (28 tablets)	_____
☐ **Tecfidera 30-day Starter Pack**		1 capsule (120mg) orally twice a day for 7 days, then 1 capsule (240mg) twice a day thereafter.	1 starter pack = 14 x 120 mg capsules and 46 x 240 mg capsules	_____
☐ **Tecfidera**	120mg	☐ 1 capsule orally twice daily ☐ Other_____	☐ 14 capsules (7 day) ☐ 28 capsules (14 day) ☐ 42 capsules (21 day) ☐ 56 capsules (28 day)	_____
☐ **Tecfidera**	240mg	☐ 1 capsule orally twice daily ☐ Other_____	60 capsules	_____

Prescriber

Physician's Name (please print):_____ Contact Name:_____
Phone #:_____ Fax #:_____ NPI #:_____
Office Address:_____ City:_____ State:_____ Zip:_____

I authorize SPS Specialty Pharmacy Services and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician's Signature:_____ Date:_____

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