CenterWell Specialty Pharmacy

Multiple Sclerosis Prescription Form

Fax: 877-405-7940
Phone: 800-486-2668
Monday – Friday, 8 a.m. – 11 p.m., and
Saturday, 8 a.m. – 6:30 p.m., Eastern time

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Patient information

Patient: _____ ❒ Female ❒ Male DOB: _____ Height: _____ Weight: _____ ❒ lb. ❒ kg Date: _____

Address: _____ City: _____ State: _____ ZIP code: _____

Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____

Other medical conditions: _____ Allergies: ❒ No ❒ Yes: _____

Insurance plan: _____ Plan ID #: _____ BIN: _____ PCN: _____ Group #: _____

*Please send a copy of the patient's prescription insurance card if available.

Clinical information

ICD-10 code: _____ ❒ New therapy ❒ Continuing therapy

Type: ❒ Clinically isolated syndrome ❒ Relapsing remitting ❒ Secondary-progressive ❒ Primary-progressive ❒ Progressive-relapsing

First clinical episode and MRI features consistent with MS? ❒ No ❒ Yes

Date of last dose: _____ Date of first/next dose: _____

Previous failed therapies, discontinuation reasons and dates:

Therapy Dates: Discontinuation reason:

_____

_____

Medication

❒Ampyra (dalfampridine)
❒Aubagio (teriflunomide)
❒Avonex
❒Bafiertam
❒Betaseron
❒Briumvi
❒Copaxone (glatiramer)
❒Extavia
❒Gilenya (fingolimod)
❒Glatopa
❒Kesimpta
❒Lemtrada
(Please complete the prescription form at www.lemtrada.com)
❒Mavenclad
❒Mayzent
❒Ocrevus
❒Plegridy
❒Ponvory
❒Rebif
❒Tecfidera (dimethyl fumarate)
❒Tysabri (Patient must be enrolled in TOUCH™ Prescribing Program. Please call 800-456-2255 or go to www.tysabri.com)
❒Vumerity
❒Zeposia

Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Dosage Form	Dose	Directions	Quantity	Refills
	Initial Dose:			
	Maintenance Dose:			
	Other:			

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____

Ship to: ❒ Patient ❒ Office ❒ Other: _____

Office address: _____ City: _____ State: _____ ZIP code: _____

Office phone number: _____ Office fax number: _____

Signature: _____ Date: _____

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: _____

The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.