JOSEFS PHARMACY

MULTIPLE SCLEROSIS ORAL AGENTS ENROLLMENT/PRESCRIPTION FORM

TOLL FREE: 855-326-9112 | FAX: 844-965-9633 or 855-326-9114 | WEB: JosefsPharmacy.com

PATIENT STATUS	PACKAGING	DELIVERY	
New Patient Current Patient New RX Refill Medicare/Medicaid Primary Caregiver:	Josef Compliance Packaging Vials (Child Proof Yes No)	Patient's home Pharmacy pickup MD's office 1st dose at MD's office and remaining refills at patient's home	Date Needed:

PATIENT INFO	PRESCRIBER INFO
Last Name, First Name Primary Language	Today's Date
Best Phone Number ( ) Alternate Phone Number ( )	Physician Name NPI #
Home Address City, State Zip	State License # DEA #:
Shipping Address (if different from home address)	Address City, State Zip
Social Security Number Date of Birth	Phone Number ( ) Fax Number ( )
Height Weight BMI Gender M F Pregnant Yes No	Key Office Contact Name Email

CLINICAL INFORMATION | PLEASE FAX LABS, CURRENT MEDICATIONS/OTC PROFILE AND HISTORY

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**

PRESCRIPTION INFORMATION OR ATTACH RX

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
Gilenya	0.5mg	Take one capsule by mouth once daily Other:	1 BOX (28 capsules)	
Aubagio	14mg 7mg	Take one capsule by mouth once daily Other:	1 BOX (28 capsules)	
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 240mg capsules	
Tecfidera	120mg 240mg	Take one capsule orally twice daily Other	14 capsules (7 day) 28 capsules (14 day) 42 capsules (21 day) 56 capsules (28 day) 60 capsules (30 day)	
OTHER (PLEASE SPECIFY):				

I authorize Josefs Pharmacy and its representatives to serve as a prior authorization designated agent in dealing with medical and prescription insurance companies and to coordinate/receive patient lab values.

Patient is interested in Patient Support Programs as necessary/applicable *Ancillary kits and supplies provided as necessary/applicable*

Doctor/Prescriber Signature – Dispense as Written Date Doctor/Prescriber Signature – Substitution Permissible Date

Rev 2/15/2014. **IMPORTANT CONFIDENTIALITY STATEMENT:** This message contains confidential, legally privileged, and/or proprietary information, intended only for the use of the named addressee above. If you are not the named addressee, you are hereby notified that any reading, retaining, disclosure, copying, distribution, or any action taken in reliance on the contents of these documents is strictly prohibited. If you have received this document in error, please notify Josefs Pharmacy immediately and destroy the transmitted information.