



AMPYRA-DALFAMPRIDINE®

Please Fax Completed Form To: **800-783-9146**

PATIENT INFORMATION (Complete or fax existing chart)		PRESCRIBER INFORMATION	
Patient Name: _____		Prescriber Name: _____	
Address: _____		State License: _____ NPI #: _____	
City, State, Zip: _____		DEA: _____ Phone: _____	
Phone: _____ 2 nd Phone: _____		Address: _____ Fax: _____	
DOB: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		City, State, Zip: _____	
Weight: _____ Ht: _____ Date: _____		Contact Person: _____	
E-mail address: _____		Phone: _____	
INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)			
Primary Insurance: _____		RX Card (PBM): _____	
City, State, Zip: _____		BIN: _____ PCN: _____	
Member ID #: _____ Phone: _____		City, State, Zip: _____	
Plan #: _____ Group #: _____		Plan #: _____ Group #: _____	
DIAGNOSIS / CLINICAL INFORMATION			
Primary ICD-10 code: _____			
Labs Drawn Date (include Serum Creatinine): _____			
Concurrent Meds: <input type="checkbox"/> OCT-2 inhibitor			
<input type="checkbox"/> NKDA <input checked="" type="checkbox"/> Known drug allergies:			
Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Expected date of first/next injection: _____		Date of last injection (if relevant): _____	
Agency nurse to visit home for injection: Yes or No		Agency name & telephone: _____	
PRESCRIPTION / ADMINISTRATION			
Medication	Strength/Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Ampyra®	10mg tablet extended release	Take one tablet by mouth every 12 hours	<input type="checkbox"/> 60 tablets (30-day supply) <input type="checkbox"/> 180 tablets (90-day supply) Refills: _____
<input type="checkbox"/> Dalfampridine	10mg tablet extended release	Take one tablet every 12 hours.	<input type="checkbox"/> 30-day supply <input type="checkbox"/> 90-day supply Refills _____
PRESCRIBER'S SIGNATURE			
X _____		Date: _____	
(Product Substitution Permitted)			

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