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: _____ 2nd Phone: _____	Address: _____ Fax: _____
DOB: _____ Gender: ☐Male ☐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: □ OCT-2 inhibitor	
□ NKDA ☐Known drug allergies:	
Pregnant: ☐Yes ☐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
❑ Ampyra®	10mg tablet extended release	Take one tablet by mouth every 12 hours	❑ 60 tablets (30-day supply) ❑ 180 tablets (90-day supply) Refills:_____
❑ Dalfampridine	10mg tablet extended release	Take one tablet every 12 hours.	❑ 30-day supply ❑ 90-day supply Refills _____

PRESCRIBER'S SIGNATURE

X _____ Date: _____

(Product Substitution Permitted)