VERMONT

GILENYA® (fingolimod) - Prior Authorization/Prescription/Patient Enrollment Form

Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION

Last Name	First Name	Middle Initial
Date of Birth	Sex M ☐ F ☐	Medicaid ID #

Allergies: ☐ NKA or _____

Street Address	City

State	County	Zip Code

Home Phone	Cell Phone

Parent/Guardian	Day Telephone	Night Telephone
Emergency Contact	Relationship	Telephone

2 PRESCRIBER INFORMATION

Prescriber's Name	NPI Number	DEA Number

Telephone Number	Fax Number	Hospital/Clinic Name

Street Address	City

State	County	Zip Code

Contact Person at Office	Prescriber Specialty

briovaRx

GHS Goold Health Systems

Fax Completed Form to:

Fax Number: 800-218-3221

Phone Number: 866-843-3604

3 Department of Vermont Health Access GILENYA® (fingolimod) PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

☐ Relapsing Multiple Sclerosis

List previous self-injectable medication tried and failed for this condition:

Medication (and dates)	Reason for discontinuation
_____	_____
_____	_____
_____	_____

Date of observed first dose: ____/____/_____ (observed for minimum of 6 hours with hourly pulse and blood pressure measurement and pre and post electrocardiogram)

Prescriber Additional Comments:

4 PRESCRIPTION

☐ Gilenya 0.5 mg capsule Dispense Quantity: 28

Sig: Take one capsule once daily.

Refill X:_____

Prescriber's Signature: _____ **Date:** _____

Last Updated 12/2014