



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 <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> 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	



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: ____/____/____

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 12/2011