



Department of Vermont Health Access
MULTIPLE SCLEROSIS ORAL MEDICATIONS
PRIOR AUTHORIZATION REQUEST

MS ORAL.2
 FORM#29
 C:2.16

PATIENT INFORMATION

Last Name		First Name	Middle Initial
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian	Day Telephone	Night Telephone	

PRESCRIBER'S 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	

Please Fax Completed for to:
Fax Number 1-800-218-3221
Phone Number 1-866-843-3604



Patient Diagnosis:

Complete for Aubagio (teriflunomide):

Patient does NOT have any of the following contraindications to teriflunomide:

- Severe hepatic impairment
- Current treatment with leflunomide (Arava®)
- Pregnancy or a woman of childbearing potential not using reliable contraception

Prescriber Additional Comments:

PRESCRIPTION

Ampyra (Dalfampridine) 10mg tablet Dispense Quantity 60
 Sig: Take one tablet by mouth twice daily Refill X: _____

Aubagio 7mg tablet or Aubagio 14mg tablet Dispense Quantity 28
 Sig: Take one tablet by mouth once daily Refill X: _____

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