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		

Ascend SpecialtyRx®

MedMetrics Health Partners an SXC company

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