RIVER'S EDGE PHARMACY
PASSION FOR LIFE

866 413-3156 toll free phone
877 834-1231 toll free fax
QUESTIONS? Please Contact Us!
www.REPharmacy.com

Tecfidera (Dimethyl Fumarate)
Prescription Referral Form

Send your RX to: (Select Location - optional)

Date Medication Needed: _____

Ship to: ☐ Patient's Home ☐ Prescriber's Office ☐ Pick-up (store location): _____

1. PATIENT & INSURANCE INFORMATION

(Please include copies of the FRONT and BACK of ALL insurance cards with this fax (Prescription and Medical)

Patient Name: _____ Birth Date: _____ Gender: ☐ Male ☐ Female

Height: _____ Weight: _____ ☐ lbs. ☐ kg.

SS#: _____ Preferred Phone: _____ Known Allergies: _____

_____

Address: _____ City: _____ State: _____ ZIP: _____

Insurance Info: _____ Policy Number: _____

2. PRESCRIBER INFORMATION (Specialty: Neurologist)

Provider Name: _____ DEA#: _____ NPI#: _____ TAX ID#: _____

Address: _____ Phone: _____ Fax: _____

City, State, ZIP: _____ Key Contact: _____ Phone #: _____

3. CLINICAL INFORMATION

Please FAX recent clinical notes, labs and/or tests, with the prescription, to expedite the prior authorization.

Past Medical History

Liver problems: ☐ Yes ☐ No Specify- _____

Herps zoster: ☐ Yes ☐ No Flushing: ☐ Yes ☐ No PML: ☐ Yes ☐ No

Pregnancy: ☐ Yes ☐ No Breat Feeding: ☐ Yes ☐ No

Other: _____

Indication(s) Relapsing forms of Multiple Sclerosis (MS), including:

Clinically isolated syndrome Relapsing – remitting disease Active secondary progressive disease

Current or most recent therapy

Prior Disease Modifying Therapy: ☐ Yes ☐ No Drug name: _____

Date: ____/____/____ Therapy Duration: _____

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4. PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	SIG	QTY.	REFILLS
☐ **Tecfidera**® Titration Starter Pack	☐ 120mg ☐ 240mg	☐ PO BID x7 Days ☐ PO BID x23 Days	☐ 14 ☐ 46	
☐ Maintenance for **Tecfidera**®	☐ 120mg ☐ 240mg	☐ PO BID x1 month ☐ PO BID		
☐ Other: _____				

5. PATIENT SUPPORT PROGRAMS

Please sign and date below to enroll in the pharmaceutical company assisted patient support program.

_____ _____

Patient Signature Date

6. PRESCRIBER SIGNATURE

Prescriber, please sign and date below. Please attach all patient-related document here.

By signing below, the prescriber gives consent to both, the prescription(s) above, as well as to River's Edge Pharmacy to act as the prescriber's agent to begin and execute prior authorization process and to help patient apply to co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

_____ _____ _____ _____

Dispense as written Date Substitution Permissable Date

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately. In no event should such material be read or retained by anyone other than the named addressee, except by express authorization of the sender to the named addressee. Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

Faxed prescriptions will only be accepted from a prescribing practitioner. Prescribers are reminded patients may choose any pharmacy of their choice.

#of Prescriptions