



CSI Pharmacy
Toll Free: 1-833-569-1005
Pharmacy Fax: 430-200-4889

- Copay Assistance Team
- 24/7 On call Pharmacist
- Prior Authorizations
- Close Clinical Monitoring

Tecfidera Enrollment Form

PATIENT INFORMATION

| | | | | |
|--|-----------------|-----------------------------------|---|----------|
| Patient Name | | Patient/Caregiver (if applicable) | | |
| Address | | City | State | Zip code |
| Main Phone | Alternate phone | Email Address | Last Four of Social (to pull ins. card) | |
| Date of Birth | | | | |
| | | | | |
| <i>Please include Facesheet, H&P and Clinicals if available (required for PA).</i> | | | | |

INSURANCE INFORMATION (or attach copy of front/back of ins card)

| | | | | |
|----------------|------------|---------------------|--|--|
| Insurance Name | | Insurance ID number | | |
| BIN number | PCN number | RX Group number | | |

MEDICATION ORDERS

- Titration:** Tecfidera 120mg 1 cap BID X 7 days
- Dispense: Tecfidera 120mg 14 caps
- Refill X ZERO
-
- Maintenance:** Tecfidera 240mg 1 cap BID thereafter
- Dispense: Tecfidera 240mg 90 caps / 30 days
- Refill X 11 or _____

PHYSICIAN INFORMATION

| | | | | |
|--|---------|------|--------------------|----------|
| Physician Name | Address | City | State | Zip Code |
| Phone | Fax | NPI | Practice Site Name | |
| Office Contact and special instructions: | | | | |

By signing this form and utilizing our services, you are authorizing CSI PHARMACY and its employees to serve as your prior authorization agent when dealing with medical and prescription insurance companies.

*This is not a valid prescription

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