Tel: 1-888-398-0028 | Fax: 1-855-278-5182

Fampridine Prescription Form

Patient Information

Name: __________________________ **DOB** (DD/MM/YYYY): ____/_____/_____ **Allergies:** ______________

Address: ____

Home #: ______________________ **Cell #:** ______________________ **Email:** _______________________

Patient initial contact via: [ ] call [ ] email **Best time to reach patient:** [ ] morning [ ] afternoon [ ] evening

[ ] Patient has consented to AccessLink receiving and using the information on this form and AccessLink contacting the patient

[ ] Verbal Consent Received by: _________________________ Date of consent: _________________________

Prescription

[ ] Fampridine 10mg Tablets 10mg orally every 12 hours [ ] Other Instruction: ___________________________

Quantity: [ ] 1 Month Refills: ______________________

EDSS Score: ____________ T25-FW: _________ seconds MSWS-12 Questionnaire Score: _______

Other Comments or Instructions:

Prescriber Info and Authorization

Clinic Contact: ___________________________ **Address:** ____

Email: ________________________ **Phone:** ___________________________ **Fax:**______________________

Prescriber Name: _______________________ **License#:** _______________________

Prescriber Signature: ______________________________ **Date:** ________________________

I confirm as a licensed healthcare professional that this patient qualifies for treatment, in accordance with the respective Product Monograph and any contraindications, warnings and precautions described therein.

Prescriber Certification.
This prescription represents the original of the prescription drug order.
The pharmacy address noted above is the only intended recipient and there are no others.
The original prescription has been invalidated and securely filed, and it will not be transmitted elsewhere at another time.