CYCLE VITA™
Support for life

Patient Enrollment Form for TASCENSO ODT® (fingolimod) Orally Disintegrating Tablets

Phone: 888-360-8482 FAX: 888-385-8482

TASCENSO ODT® (fingolimod)

To Enroll, Fax this form:
888-385-8482
Or email: hello@cyclevita.life

All required fields are purple and noted with an asterisk*

PATIENT INFORMATION

Patient Last Name*		Patient First Name*
Date of Birth*	Gender* ☐ Male ☐ Female ☐ Other	
Parent/Guardian Name *(if patient is a minor) / Caregiver Name*	Relationship to Patient	Power of Attorney/Medical Proxy ☐ Yes ☐ No
Street Address*		Suite/Floor/Apt #
City*	State*	Zip code*
Preferred Method of Contact (please specify)* ☐ Cell Phone ☐ Alternate Phone		
☐ Email		
Language Preferred: ☐ English ☐ Spanish ☐ Other (please specify):		

PRESCRIBER INFORMATION

Prescriber Last Name* :	Prescriber First Name* :	
Prescriber Office/Site/Clinic*		
Prescriber Phone Number*	Prescriber Fax Number*	
Prescriber Medicaid Number*	Prescriber Tax ID*	
Street Address*		
City*	State*	Zip Code*
NPI Number*		
Office Contact Name		
Office Contact Phone Number with extension	Office Email Address	

INSURANCE INFORMATION

Please attach a copy of the prescription insurance benefit card, front and back, or complete the following*

☐ Prescription insurance benefit card attached. ☐ Patient does not have insurance. ☐ Patient requires co-pay only.

Primary Insurance Company Name*		Secondary Insurance Company Name	
Primary Insurance Company Phone Number*		Secondary Insurance Company Phone Number	
Name of Primary Cardholder*		Name of Primary Cardholder	
Primary Insurance Member ID*	Group ID*	Secondary Insurance Member ID	Group ID
BIN*	PCN*	BIN	PCN

Prior Authorization Status

☐ Submitted ☐ Not submitted ☐ Approved ☐ Denied

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Patient Full Name:	Date of Birth:

CLINICAL INFORMATION

☐ Please specify ICD-10 code*:

- ☐ G35.A: Relapsing-remitting MS
- ☐ G35.C0: Secondary progressive multiple sclerosis, unspecified
- ☐ G35.C1: Active secondary progressive multiple sclerosis
- ☐ G35.D: Multiple sclerosis, unspecified
- ☐ G36.8: Other specified acute disseminated demyelination
- ☐ G36.9: Acute disseminated demyelination, unspecified
- ☐ G37.8: Other specified demyelinating diseases of the central nervous system
- ☐ G37.9: Demyelinating disease of the central nervous system, unspecified
- ☐ Other (please specify): _____

Patient Allergies*:

☐ None Known ☐ Known (please list known allergies): _____

Most recent Treatment:

☐ None ☐ BRAND Gilenya ☐ GENERIC Fingolimod ☐ Any other DMT

Please send patient full medication list in with enrollment form if available.

Initiating Therapy

Patients who are currently treated with another fingolimod product and underwent a First Dose Observation at initiation may be switched to TASCENSO ODT at the same daily dose without a need to repeat a First Dose Observation (unless the previous treatment was discontinued more than 14 days prior).

☐ The above statement is true for this patient, Baseline Assessments and a First Dose Observation are not required. (Please leave the rest of the Clinical Information section blank and move to the Prescription Information section on the next page.)

Baseline assessments

☐ I am requesting that Cycle Vita™ perform the following Baseline Assessments:

☐ CBC ☐ LFTs and Bilirubin ☐ VZV Antibody Serology ☐ ECG ☐ Macular Edema Screening

Would you like assistance from Cycle Vita in setting up an FDO (First Dose Observation)?

☐ Yes ☐ No

First Dose Observations

TASCENSO ODT Starter Pack:

☐ *Body weight ≤ 40 kg (88.2 lbs):* Dispense one (1) carton (30 tablets) of TASCENSO ODT *0.25 mg*, one tablet taken by mouth once a day

☐ *Body weight ≥ 40 kg (88.2 lbs):* Dispense one (1) carton (30 tablets) of TASCENSO ODT *0.5 mg*, one tablet taken by mouth once a day

☐ Alternative Instructions (please specify): _____

TASCENSO ODT Starter Pack Shipping Address:
The Starter Pack is always sent to the FDO administrator and subsequent fills will be sent to the patient's address.

FDO to be performed:

☐ In-home by Cycle Vita

☐ In-clinic

Clinic address:

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

Phone: _____

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Patient Full Name:	Date of Birth:

PRESCRIPTION INFORMATION

Quantity: _____ tablets

Number of days' supply/prescription:
☐ 30 days followed by 11 refills ☐ 90 days followed by 3 refills
☐ 30 days followed by ____ refills ☐ 90 days followed by ____ refills

☐ TASCENSO ODT, 0.25 mg	NDC Number: 70709-062-30
☐ TASCENSO ODT, 0.5 mg	NDC Number: 70709-065-30

Only prescriptions filled with product NDC numbers listed above shall be eligible for Cycle Vita (Eligible Products).

Patient Directions (check all that apply):

☐ Take one 0.25 mg TASCENSO ODT tablet by mouth once a day with or without food, for a total dose of *0.25 mg*/day.

☐ Take one 0.5 mg TASCENSO ODT tablet by mouth once a day with or without food, for a total dose of *0.5 mg*/day.

☐ Other (please specify): _____

Shipping Instructions (check if applicable):

☐ Dispensing pharmacy to notify prescriber when initial shipment is scheduled.

☐ Bridge† - "Bridge" is a FREE supply of TASCENSO ODT that allows patients already on a fingolimod product, with an urgent medical need to begin therapy immediately while Cycle Vita secures appropriate benefit verification and authorization. Bridge may also be requested for existing patients who are temporarily experiencing disruption in therapy due to insurance coverage.

By checking the box above for Bridge, I, as the prescriber, with my signature below on this form, agree and attest that I will not submit a claim to or seek payment from the patient or any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment/reimbursement for any free product(s) provided by Cycle Vita. I agree and understand that any free product provided by Cycle Vita may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on this form. Cycle Vita reserves the right to modify or terminate the program without notice at any time.

† Bridge is at no cost, for eligible patients within labeled indication only, and not contingent on purchase of any kind. Bridge is intended to support continuation of prescribed therapy if there is any disruption in therapy due to insurance coverage.

PRESCRIBER DECLARATION

Prescriber Declaration: I understand and agree that, as the prescriber, I will comply with my state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to me, as the prescriber. I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed TASCENSO ODT based on my professional judgment of medical necessity. I authorize Cycle Vita, its affiliates, agents, and contractors (collectively, "Cycle Vita" to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the above-named patient utilizing their benefit plan. I authorize Cycle Vita, its affiliates, agents and contractors to perform any steps necessary to secure reimbursement for TASCENSO ODT, including but not limited to insurance verification and case assessment. I understand that Cycle Vita may need additional information, and I agree to provide it as needed for the purposes of securing reimbursement.

X _____	_____	_____
Prescriber Signature	(Substitution Permitted)	Date of Signature
Dispense as Written		(MM/DD/YYYY)

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