Multiple Sclerosis
Prescription/Referral Form

Please complete this form (Print) in it's entirely. Be sure to include any necessary documentation, labs, insurance cards, etc

2 Penns Way, Ste# 404
New Castle, DE 19720
Tel: (877)246-9104
Fax: (302)544-5018
www.biotekrx.com

Ship to: ☐Patient ☐Office ☐Other: **Date need by:**_____

Patient Information

Patient Name:_____

Address: _____

City,State,Zip:_____

Home Phone:_____

Alternate Phone:_____

SSN#_____-_____-_____ **Primary Language:**_____

Date of Birth:_____ **Gender:**_____

Prescriber Information

Prescriber's Name:_____

State License #: _____ **UPIN:**_____

DEA:_____ **NPI:**_____

Practice Name:_____

Address:_____

City, State, Zip:_____

Phone:_____ **Fax:**_____

Contact Person:_____ **Phone:**_____

INSURANCE INFORMATION (Please copy and attach the front and back of insurance and prescription card)

Prescription Card: **Name of Insurer:**_____ **ID#:** _____ **BIN:**_____**PCN:**_____ **Group:**_____

Primary Insurance: **Name of Insurer:**_____ **ID#:** _____**BIN:**_____**PCN:**_____**Group:**_____

Secondary Insurance: **Name of Insurer:**_____ **ID#:** _____ **BIN:**_____ **PCN:**_____ **Group:**_____

STATEMENT OF MEDICAL NECESSITY

Diagnosis:
☐**Multiple Sclerosis 340** ☐**Other:**_____

Medical Assessment: (Type of MS)
☐**Primary Progressive** ☐**Secondary Progressive**
☐**Relapsing-Remitting**
☐**Other:**_____

☐**Allergies:**_____

Patient Evaluation:

- Has Patient been treated previously for this condition? ☐Yes ☐No
  Medications failed:_____
- Is patient currently on therapy? ☐Yes ☐No
  Type/mediation(s):_____
- Will patient stop taking the above medication(s) before starting the new mediation? ☐Yes ☐No

Other current medications:_____

Medication	Strength/Formulation	Refills	Qty	Directions
☐Avonex vials ☐Avonex prefilled Syringes ☐Avonex Pen	☐30mcg			☐IM weekly ☐Alternate dosing: _____
☐Betaseron	☐0.3mg			☐SQ every other day ☐Alternate dosing:_____
☐Copaxone	☐20mg			☐SQ every day ☐Alternate dosing:_____
☐Rebif Starter Pak	**22mcg Titration Schedule** ☐Week 1-2: 4.4mcg (0.1ml) SQ TIW ☐Week 3-4: 11mcg (0.25ml) SQ TIW ☐Week 5+: 22mcg (0.5ml) SQ TIW			**44mcg Titration Schedule** ☐Week 1-2: 8.8mcg (0.1ml) SQ TIW ☐Week 3-4: 22mcg (0.25ml) SQ TIW ☐Week 5+: 44mcg (0.5ml) SQ TIW
☐Rebif	☐22mcg Maintenance ☐44mcg Maintenance			☐TIW (48 hours apart) ☐Alternate dosing:_____
☐Gilenya	☐0.5mg			☐Oral 0.5mg Daily ☐Alternate dosing:_____
☐Extavia	☐0.3mg			☐0.25 mg injected subcutaneously every other day ☐Alternative dosing:_____
☐Other				

By signing below, I authorize BioTek reMEDys to: Collect my health condition and prescription information from my doctor, healthcare provider, health insurer or pharmacist in order to ensure its accuracy and completeness and to communicate to the patient support program of the pharmaceutical manufacturer (the program); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I herby authorize my doctor, healthcare provider, health insurer or pharmacist to provide my health condition and prescription information to BioTek reMEDys and to the program. I understand that I may revoke this authorization at anytime by sending a letter to BioTek reMEDys at 2 Penns Way, Ste#404, New Castle, De, 19720.

Patient's Signature: _____ Date: _____

Prescriber Signature: _____ _____ Date: _____
(Substitution Allowed) (Brand Medically Necessary)

Fax completed form to: (302)544-5018
Thank you for using BioTek reMEDys!