



# Multiple Sclerosis Prescription/Referral Form

Phone: (877)-246-9104  
Fax: (888) 963-8122

WWW.Biotekrx.com

Ship to:  Patient  Office  Other Date needed by: \_\_\_\_\_

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber's Name: _____
Address: _____	State License#: _____ UPIN: _____
City, State, Zip: _____	DEA: _____ NPI: _____
Home Phone: _____	Practice Name: _____
Alternate Phone: _____	Address: _____
SS# _____ - _____ - _____ Primary Language: _____	City, State, Zip: _____
DOB: _____ Gender: _____	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**

<b>Diagnosis:</b> <input type="checkbox"/> Multiple Sclerosis 340 <input type="checkbox"/> Other: _____  <b>Medical Assessment: (Type of MS):</b> <input type="checkbox"/> Primary Progressive <input type="checkbox"/> Secondary Progressive <input type="checkbox"/> Relapsing-Remitting <input type="checkbox"/> Other: _____ <input type="checkbox"/> Allergies: _____	<b>Patient Evaluation:</b> • Has patient been treated for this condition previously? <input type="checkbox"/> Yes <input type="checkbox"/> No Medications failed: _____ • Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Medication(s): _____ • Will patient stop taking the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Other current Medications:</b> _____
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Medication	Strength/Formulation	Refills	Qty	Directions
<input type="checkbox"/> Avonex vials <input type="checkbox"/> Avonex prefilled Syringes <input type="checkbox"/> Avonex Pen	<input type="checkbox"/> 30mcg			<input type="checkbox"/> IM weekly <input type="checkbox"/> Alternate dosing: _____
<input type="checkbox"/> Betaseron	<input type="checkbox"/> 0.3mg			<input type="checkbox"/> SQ every other day <input type="checkbox"/> Alternate dosing: _____
<input type="checkbox"/> Copaxone	<input type="checkbox"/> 20mg			<input type="checkbox"/> SQ every other day <input type="checkbox"/> Alternate dosing: _____
<input type="checkbox"/> Rebif Starter Pak	<b>22mcg Titration Schedule</b> <input type="checkbox"/> Week 1-2: 4.4mcg (0.1mL) SQ TIW <input type="checkbox"/> Week 3-4: 11mcg (0.25mL) SQ TIW <input type="checkbox"/> Week 5+: 22mcg (0.5mL) SQ TIW			<b>44mcg Titration Schedule</b> <input type="checkbox"/> Week 1-2: 8.8mcg (0.1mL) SQ TIW <input type="checkbox"/> Week 3-4: 22mcg (0.25mL) SQ TIW <input type="checkbox"/> Week 5+: 44mcg (0.5mL) SQ TIW
<input type="checkbox"/> Rebif	<input type="checkbox"/> 22mcg Maintenance <input type="checkbox"/> 44mcg Maintenance			<input type="checkbox"/> TIW (48 hours apart) <input type="checkbox"/> Alternate dosing: _____
<input type="checkbox"/> Gilenya	<input type="checkbox"/> 0.5mg			<input type="checkbox"/> Oral 0.5mg Daily <input type="checkbox"/> Alternate dosing: _____
<input type="checkbox"/> Extavia	<input type="checkbox"/> 0.3mg			<input type="checkbox"/> 0.25mg injected subcutaneously every other day <input type="checkbox"/> Alternate dosing: _____
<input type="checkbox"/> 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 hereby 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 any time by sending a letter to BioTek reMEDys at 7227 Fannin Street STE #103, Houston, TX 77030.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Substitution Allowed)

(Brand Medically Necessary)

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Fax completed form to (888) 963-8122. Thank you for using BioTek reMEDys®