BioTek reMEDys
WWW.Biotekrx.com

# Multiple Sclerosis
## Prescription/Referral Form

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

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

## PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS#____-____-____ Primary Language: _____
DOB: _____ 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 for this condition previously? ☐Yes ☐No
  Medications failed: _____
- Is patient currently on therapy? ☐Yes ☐No
  Type/Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ☐Yes ☐No

**Other current Medications:** _____

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

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



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