Copaxone®

Phone: (346) 708-5160
Fax: (888) 963-8103

www.biotekrx.com

PATIENT INFORMATION (Complete or fax existing chart)	PRESCRIBER INFORMATION
Patient Name: ______________________________	Prescriber Name: ______________________________
Address: ______________________________	State License: ______________ NPI #: ______________
City, State, Zip: ______________________________	DEA: ______________ Phone: ______________
Phone: ______________ 2nd Phone: ______________	Address: ____________________ Fax: ______________
DOB: ______________ Gender: ☐ Male ☐ Female	City, State, Zip: ______________________________
Weight: ________ Ht: ________ Date: ______________	Contact Person: ______________________________
E-mail address: ______________________________	Phone: ______________

INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)	
Primary Insurance: ______________________________	RX Card (PBM): ______________________________
City, State, Zip: ______________________________	BIN: ______________ PCN: ______________
Member ID #: ______________ Phone: ______________	City, State, Zip: ______________________________
Plan #: ______________ Group #: ______________	Plan #: ______________ Group #: ______________

DIAGNOSIS / CLINICAL INFORMATION	
Primary ICD-10 code:	
Pregnant: ☐ Yes ☐ No	
☐ NKDA ☐ Known drug allergies:	
Concurrent Meds:	
Expected date of first/next injection:	Date of last injection (if relevant):
Agency nurse to visit home for injection: ☐ Yes ☐ No	Agency name & telephone:

PRESCRIPTION / ADMINISTRATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Copaxone®	❑ 20mg PFS	❑ Inject 20mg subcutaneously daily. ❑ Other: ______________________________	❑ 30-day supply (1 kit/30 syr) ❑ 90-day supply (3 kits/90 syr) Refills ______________
	❑ 40mg PFS	❑ Inject 40mg subcutaneously three times a week.	❑ 28-day supply (1 kit/12 syr) ❑ 84-day supply (3 kits/36 syr) Refills ______________
❑ Glatiramer acetate or Glatopa	❑ 20mg PFS	❑ Inject 20mg subcutaneously daily. ❑ Other: ______________________________	❑ 30-day supply (1 kit/30 syr) ❑ 90-day supply (3 kits/90 syr) Refills ______________
	❑ 40mg PFS	❑ Inject 40mg subcutaneously three times a week	❑ 28-day supply (1 kit/12 syr) ❑ 84-day supply (3 kits/36 syr) Refills ______________

SIGNATURE

X ____ Date: ______________________
(Product Substitution Permitted)

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