BioTek reMEDys

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

www.biotekrx.com

Gilenya®

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:	Diagnosis:
Labs Drawn Date:	
☐ AST	
☐ ALT	
☐ Bilirubin	
EKG: ☐ Yes ☐ No **Date done**:	
☐ JCV virus testing	
Pregnant: ☐ Yes ☐ No	
☐ NKDA ☐ Known drug allergies:	
Concurrent Meds: ☐ Immunosuppressants	

PRESCRIPTION / ADMINISTRATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Gilenya® (fingolimod)	0.5mg capsule	Take one 0.5mg capsule by mouth once daily.	❑ 30-day supply #30 ❑ 90-day supply #90 Refills _____
	0.25mg capsule	Take one 0.25mg capsule by mouth once daily. (Adolescents <40 kg dosage)	

PRESCRIBER'S SIGNATURE

X _____ Date: _____

(Product Substitution Permitted)

Fax completed form to: (888) 963-8103 - Thank you for using BioTek reMEDys®