



Gilenya®

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: _____ 2 nd Phone: _____	Address: _____ Fax: _____
DOB: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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: _____	
<input type="checkbox"/> AST	
<input type="checkbox"/> ALT	
<input type="checkbox"/> Bilirubin	
EKG: <input type="checkbox"/> Yes <input type="checkbox"/> No Date done: _____	
<input type="checkbox"/> JCV virus testing	
Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> NKDA <input type="checkbox"/> Known drug allergies: _____	
Concurrent Meds: <input type="checkbox"/> Immunosuppressants	

PRESCRIPTION / ADMINISTRATION

Medication	Strength/Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Gilenya® (fingolimod)	0.5mg capsule	Take one 0.5mg capsule by mouth once daily.	<input type="checkbox"/> 30-day supply #30 <input type="checkbox"/> 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)

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