



Kesimpta®

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: _____

Hep B panel:

Quantitative Immunoglobulin

Tried and failed medications: _____

Concurrent Meds: _____

NKDA Known drug allergies:

Pregnant: Yes or No _____

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
<input type="checkbox"/> Kesimpta® (ofatumumab)	20mg (0.4mL) <input type="checkbox"/> Prefilled syringes <input type="checkbox"/> Sensoready pens	<input type="checkbox"/> Loading dose: Inject 1 unit (0.4mL) subcutaneously at week 0, 1 and 2. <input type="checkbox"/> Maintenance dose: Inject 1 unit (0.4mL) each month.	Supply: <input type="checkbox"/> 4-week supply <input type="checkbox"/> 12-week supply <input type="checkbox"/> Other _____ Refills _____

PRESCRIBER'S SIGNATURE

X _____ Date: _____
(Product Substitution Permitted)

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