BioTek reMEDys®

COPAXONE®

Please Fax Completed Form To: 800-783-9146

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ DEA: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: _____
City, State, Zip: _____
Plan #: _____
Group #: _____
Phone: _____

RX Card (PBM): _____
BIN: _____ PCN: _____
City, State, Zip: _____
Group #: _____
Phone: _____

CLINICAL INFORMATION

Primary ICD-10 code:	☐ NKDA ☐ Known drug allergies:
Pregnant: ☐ Yes ☐ No	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:

(DRUG NAME) ORDERS – this section may not be needed)

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Infusion/Injection: _____

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

Pre-medication: _____

SIGNATURE

X_____ Date: _____

Prescriber Signature