BioTek reMEDys®

GILENYA®

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:	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

(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
☐Gilenya® (fingolimod) 0.5mg capsule	☐Take one 0.5 mg capsule by mouth once daily	☐30-day supply ☐90-day supply
☐Gilenya® (fingolimod) 0.25mg capsule	☐Take one 0.25 mg capsule by mouth once daily	Refills: __________

Pre-medication: ______________________________________

SIGNATURE

X______________________________________ Date: ________________

Prescriber Signature

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