BioTek reMEDys®

KESIMPTA®

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:	☐ Tried and failed medications:
☐ Hep B panel:	☐ Concurrent Meds:
☐ Quantitative Immunoglobulin	☐NKDA ☐ Known drug allergies
Pregnant: ☐ Yes ☐ No	Expected date of first/next injection: _____ Date of last injection (if relevant): _____
Agency nurse to visit home for injection: ☐ Yes ☐ No	Agency name and 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
☐ Kesimpta® (ofatumumab) 20mg (0.4mL) ☐Prefilled syringes ☐Sensoready pens	☐Loading dose: Inject 1 unit (0.4mL) subcutaneously at week 0, 1 and 2. ☐ Maintenance dose: Inject 1 unit (0.4mL) each month.	Supply: ❑ 4-week supply ❑ 12-week supply Other __ Refills ___

Pre-medication: _____

SIGNATURE

X_____ Date: _____

Prescriber Signature