Multiple Sclerosis Injectables

Phone: (877)-246-9104
Fax: (800) 783-9146
www.biotekrx.com

PATIENT INFORMATION			PRESCRIBER INFORMATION	
Patient Name:			Prescriber Name:	
Address:			State License:	NPI#:
City, State, Zip:			DEA:	Phone:
Phone:	2nd Phone:		Address:	Fax:
DOB:	Gender: ☐ Male ☐ Female		City, State, Zip:	
Weight:	Ht:	Date:	Contact Person:	

INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)

Prescription Card: Name of Insurer: _____ ID# _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Name of Insurer: _____ ID# _____ BIN: _____ PCN: _____ Group: _____
Secondary Insurance: Name of Insurer: _____ ID# _____ BIN: _____ PCN: _____ Group: _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis:
☐ Multiple Sclerosis 340 ☐ Other: _____

Medical Assessment: (Type of MS):
☐ Primary Progressive ☐ Secondary Progressive
☐ Relapsing-Remitting
☐ Other: _____
☐ Allergies: _____
_____

Patient Evaluation:
- Has patient been treated for this condition previously? ☐ Yes ☐ No
  Medications failed: _____
- Is patient currently on therapy? ☐ Yes ☐ No
  Type/Medication(s): _____
- Will patient discontinue the above medication(s) before starting the new medication? ☐ Yes ☐ No

Other current medications: _____
_____

Medication	Strength/Formulation	Refills	Qty	Directions
☐ Avonex vials ☐ Avonex prefilled syringes ☐ Avonex pen	☐ 30 mcg			☐ IM weekly ☐ Alternate dosing: _____
☐ Betaseron	☐ 0.3 mg			☐ SQ every other day ☐ Alternate dosing: _____
☐ Rebif Starter Pak	**22 mcg Titration Schedule** ☐ Week 1-2: 4.4 mcg (0.1 mL) SQ TIW ☐ Week 3-4: 11 mcg (0.25mL) SQ TIW ☐ Week 5+: 2 2 mcg (0.5 mL) SQ TIW			**44 mcg Titration Schedule** ☐ Week 1-2: 8.8 mcg (0.1 mL) SQ TIW ☐ Week 3-4: 22 mcg (0.25 mL) SQ TIW ☐ Week 5+: 44 mcg (0.5 mL) SQ TIW
☐ Rebif	☐ 22 mcg Maintenance ☐ 44 mcg Maintenance			☐ TIW (48 hours apart) ☐ Alternate dosing: _____
☐ Extavia	☐ 0.3 mg			☐ 0.25 mg injected subcutaneously every other day ☐ Alternate dosing: _____
☐ Other				

By signing below, I authorize BioTek reMEDys to collect my health condition information, prescription information from my doctor, healthcare provider, health insurer, or pharmacist in order to ensure its accuracy and completeness, to communicate to the patient support program of the pharmaceutical manufacturer (the program); and contact my insurer, other potential funding sources, social workers, patient advocacy organizations, and patient assistance programs on my behalf to determine if I am eligible for assistance. I hereby authorize my doctor, healthcare provider, health insurer, or pharmacist to provide my health condition, prescription information to BioTek reMEDys, and to the program. I understand that I may revoke this authorization at any time by sending a letter to BioTek reMEDys at BioTek reMEDys at 7227 Fannin Street Ste #103, Houston, TX 77030.

Patient's Signature: _____ **Date:** _____

Prescriber's Signature: _____ _____ **Date:** _____
(Substitution Allowed) (Brand Medically Necessary)

Fax completed form to: (800) 783-9146 - Thank you for using BioTek reMEDys®