



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: _____	2 nd Phone: _____	Address: _____		Fax: _____	
DOB: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Multiple Sclerosis 340 <input type="checkbox"/> Other: _____ Medical Assessment: (Type of MS): <input type="checkbox"/> Primary Progressive <input type="checkbox"/> Secondary Progressive <input type="checkbox"/> Relapsing-Remitting <input type="checkbox"/> Other: _____ <input type="checkbox"/> Allergies: _____		Patient Evaluation: • Has patient been treated for this condition previously? <input type="checkbox"/> Yes <input type="checkbox"/> No Medications failed: _____ • Is patient currently on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Medication(s): _____ • Will patient discontinue the above medication(s) before starting the new medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Other current medications: _____			
Medication	Strength/Formulation	Refills	Qty	Directions	
<input type="checkbox"/> Avonex vials	<input type="checkbox"/> 30 mcg			<input type="checkbox"/> IM weekly	
<input type="checkbox"/> Avonex prefilled syringes				<input type="checkbox"/> Alternate dosing: _____	
<input type="checkbox"/> Avonex pen					
<input type="checkbox"/> Betaseron	<input type="checkbox"/> 0.3 mg			<input type="checkbox"/> SQ every other day	
				<input type="checkbox"/> Alternate dosing: _____	
<input type="checkbox"/> Rebif Starter Pak	22 mcg Titration Schedule <input type="checkbox"/> Week 1-2: 4.4 mcg (0.1 mL) SQ TIW <input type="checkbox"/> Week 3-4: 11 mcg (0.25mL) SQ TIW <input type="checkbox"/> Week 5+: 2 2 mcg (0.5 mL) SQ TIW			44 mcg Titration Schedule <input type="checkbox"/> Week 1-2: 8.8 mcg (0.1 mL) SQ TIW <input type="checkbox"/> Week 3-4: 22 mcg (0.25 mL) SQ TIW <input type="checkbox"/> Week 5+: 44 mcg (0.5 mL) SQ TIW	
<input type="checkbox"/> Rebif	<input type="checkbox"/> 22 mcg Maintenance <input type="checkbox"/> 44 mcg Maintenance			<input type="checkbox"/> TIW (48 hours apart) <input type="checkbox"/> Alternate dosing: _____	
<input type="checkbox"/> Extavia	<input type="checkbox"/> 0.3 mg			<input type="checkbox"/> 0.25 mg injected subcutaneously every other day <input type="checkbox"/> Alternate dosing: _____	
<input type="checkbox"/> Other					
<p>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.</p>					
Patient's Signature: _____		Date: _____			
Prescriber's Signature: _____		Date: _____			
(Substitution Allowed)		(Brand Medically Necessary)			

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