Vumerity®

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

PATIENT INFORMATION (Complete or fax existing chart)	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: _____
E-mail address: _____	Phone: _____

INSURANCE INFORMATION: Copy and attach the front and back of insurance and prescription card(s)	
Primary Insurance: _____	RX Card (PBM): _____
City, State, Zip: _____	BIN: _____ PCN: _____
Member ID #: _____ Phone: _____	City, State, Zip: _____
Plan #: _____ Group #: _____	Plan #: _____ Group #: _____

DIAGNOSIS / CLINICAL INFORMATION	
Primary ICD-10 code:	
Pregnant: ☐ Yes ☐ No	
☐Hep B panel:	
☐Quantitative Immunoglobulin	
Tried and failed medications:	
☐NKDA ☐Known drug allergies:	
Concurrent Meds:	
Expected date of first/next injection:	Date of last injection (if relevant):
Agency nurse to visit home for injection: Yes or No	Agency name & telephone:

PRESCRIPTION / ADMINISTRATION

Medication	Strength/Formulation	Directions	Quantity/Refills
☐ Vumerity™ (diroximel fumarate)	☐ 231mg delayed-release capsules	☐ Starting dose: take 231mg capsule twice a day for 7 days. ☐ Maintenance dose after 7 days: 462mg (administered as two 231mg capsules) twice a day, orally.	Supply: ❑ 30-day ❑ 90-day ❑ Other _____ Refills _____

PRESCRIBER'S SIGNATURE

X _____ Date: _____
(Product Substitution Permitted)

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