



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: _____ 2 <sup>nd</sup> Phone: _____		Address: _____ Fax: _____	
DOB: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Hep B panel:			
<input type="checkbox"/> Quantitative Immunoglobulin			
Tried and failed medications: _____			
<input type="checkbox"/> NKDA <input type="checkbox"/> 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
<input type="checkbox"/> Vumerity™ (diroximel fumarate)	<input type="checkbox"/> 231mg delayed-release capsules	<input type="checkbox"/> Starting dose: take 231mg capsule twice a day for 7 days. <input type="checkbox"/> Maintenance dose after 7 days: 462mg (administered as two 231mg capsules) twice a day, orally.	Supply: <input type="checkbox"/> 30-day <input type="checkbox"/> 90-day <input type="checkbox"/> Other _____ Refills _____
PRESCRIBER'S SIGNATURE			
X _____ (Product Substitution Permitted)		Date: _____	

**CONFIDENTIALITY STATEMENT:** This facsimile and documents accompanying this transmission contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.

If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited.

If you have received this information in error, please notify the sender at the address and telephone number set forth herein and arrange for return or destruction of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.

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