Carbaglu® (carglumic acid) for oral use — PRESCRIPTION & ENROLLMENT FORM

❑ New patient
❑ Current

1 PATIENT INFORMATION

Patient name ____________________
Date of birth ____________ ❑ Male ❑ Female Last 4 digits of SSN ____________
Street address ____________________ Apt # ________
City ____________________ State ______ Zip ________
Parent/guardian (if applicable) ____________________
Home phone ____________ Work phone ____________
Cell phone ____________ Evening phone ____________
E-mail address ____________________
Insurance company name ____________________
Insurance company phone # ____________________
Insured name ____________________
Insured employer ____________________
Relationship to patient ____________________
Identification # ____________ Policy/Group # ____________
Prescription card ____________ ❑ Yes ❑ No If yes, carrier ____________
Policy # ____________ Group # ____________
Is patient eligible for Medicare? ❑ Yes ❑ No

Please attach copy of front and back of patient's insurance cards, if available.

2 PRESCRIBER INFORMATION

Prescriber name ____________________
Office contact ____________________
Clinic/hospital affiliation ____________________
Street address ____________________ Suite # ________
City ____________________ State ______ Zip ________
Phone ____________ Fax ____________
E-mail address ____________________
NPI # ____________ License # ____________
MD specialty ____________________

To reach your team, call toll-free **1 888 454-8860.**
Please fax completed form to the *Carbaglu* team at 1 888 454-8488.

3 CLINICAL INFORMATION

Baseline ammonia level ____________ **umol/L**
Test date ____________ Patient wt ________ kg Date wt obtained ________
❑ NKDA ❑ Known drug allergies: ____________________
Primary ICD-9 code: ________ ________ (Please complete code to indicate status of condition)
Primary diagnosis: ____________________
Secondary ICD-9 code: ________ ________ (Please complete code to indicate status of condition)
Secondary diagnosis: ____________________
Concomitant therapies: ____________________
____
Clinical impression: ____________________
____

4 PRESCRIBING INFORMATION

(Please consult Carbaglu P.I. for full dosing information.)

Rx: *Carbaglu* 200-mg tablet

Dosage:

Acute hyperammonemia due to NAGS deficiency:
Recommended initial dose range is 100 mg/kg/day to 250 mg/kg/day divided into 2–4 doses per day.

Maintenance therapy for chronic hyperammonemia due to NAGS deficiency:
Adjust dose to maintain normal plasma ammonia levels.
Total daily dose is ________ grams; equaling ________ tablets **per day** (to be divided into 2–4 doses per day).

Sig: Dissolve ________ 200-mg tablets in a minimum of 2.5 mL of water per tablet and administer immediately. Take this dose ________ times per day. Do not swallow the tablets whole or crushed. Please instruct patient on the proper storage conditions (see full PI for more information).

Quantity of bottles: ________ (60 tablets per bottle) Refills: ________ or

Quantity of bottles: ________ (5 tablets per bottle) Refills: ________

Ancillary: ❑ Oral syringe

By signing below, I certify that Carbaglu therapy is necessary for this patient, and I will be supervising the patient's treatment accordingly.

Prescriber's printed name ____________________
Prescriber's signature (sign below) **Date** ____________

____________________ ____________________
Dispense as written **Substitution allowed**

(Physician attests this is his/her legal signature. **NO STAMPS)**

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AHG-00388-070511 amc3552

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