Cystadane® (betaine) PRESCRIPTION & ENROLLMENT FORM

❑ New Patient
❑ Current

1 PATIENT INFORMATION

Patient's 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 No. ______
Insured's Name ______
Insured's Employer ______
Relationship to Patient ______
Identification No.______ Policy/Group No. ______
Prescription Card ❑ No ❑ Yes If Yes, Carrier ______
Policy No. ______ Group No. ______
Is patient eligible for Medicare? ❑ No ❑ Yes

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

2 PRESCRIBER INFORMATION

Prescriber's Name ______
Office Contact ______
Clinic / Hospital Affiliation ______
Street Address______Suite # ______
City ______ State ______ Zip ______
Phone ______ Fax ______
NPI No. ______ License No.______
DEA No. ______
Physician Medicaid UPIN No.______
MD Specialty ______

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

3 CLINICAL INFORMATION

Primary ICD-9 Code: ______

❑ Homocystinuria (270.4)
❑ Other ______
❑ NKDA ❑ Known Drug Allergies: ______

Current weight ______ (please specify kg or lbs)
Date Measured ______
Approximate number of doses on hand ______

Rx: ❑ Cystadane (betaine)

Sig: Dissolve ______ scoop(s) in 4-6 ounces of water, juice, milk or formula and drink solution immediately. (Note: 1 scoop = 1 gram)

Solution should be taken ______ time(s) daily.

Quantity to dispense in bottles______ (whole numbers only), to provide a ______ day supply.

Each bottle contains 180 grams of Cystadane

Refills: ______

Shipping Instructions:
Medication will be shipped to the patient's home address.

By signing below, I certify that the above therapy is medically necessary.

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)**

accredo
a medco company

Accredo Health Group, Inc., is a wholly owned subsidiary of Medco Health Solutions, Inc.
© 2008 Medco Health Solutions, Inc. All rights reserved.
CDN-00004-082008