

Please fax all pages of completed form to your Carbaglu team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to [MyAccredoPatients.com](https://MyAccredoPatients.com) to log in or get started.

Prescription & Enrollment Form

Carbaglu® (carglumic acid)—for oral use

**accredo**®  
677 Ala Moana Blvd., Suite 404,  
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

## 1 Patient Information



Please provide copies of front and back of all medical and prescription insurance cards.

New patient      Current patient

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_

Preferred patient first name \_\_\_\_\_ Preferred patient last name \_\_\_\_\_

Sex at birth:    Male    Female    Gender identity \_\_\_\_\_ Pronouns \_\_\_\_\_ Last 4 digits of SSN \_\_\_\_\_

Date of birth \_\_\_\_\_ Street address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Parent/guardian (if applicable) \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

Alternate caregiver/contact \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Email address \_\_\_\_\_

OK to leave message with alternate caregiver/contact

Patient's primary language:    English    Other    If other, please specify \_\_\_\_\_

## 2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date \_\_\_\_\_ Time \_\_\_\_\_ Date medication needed \_\_\_\_\_

Office/clinic/institution name \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_

Prescriber's title \_\_\_\_\_ If NP or PA, under direction of Dr. \_\_\_\_\_

Office phone \_\_\_\_\_ Fax \_\_\_\_\_ NPI # \_\_\_\_\_ License # \_\_\_\_\_

Office contact and title \_\_\_\_\_ Office contact email \_\_\_\_\_

Office street address \_\_\_\_\_ Suite # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Deliver product to:    Prescriber's office    Patient's home

## 3 Clinical Information

Primary ICD-10 code (REQUIRED): \_\_\_\_\_

Baseline ammonia level \_\_\_\_\_ umol/L    Test date \_\_\_\_\_ Weight \_\_\_\_\_ kg/lbs    Date recorded \_\_\_\_\_

Clinical impression \_\_\_\_\_

NKDA    Known drug allergies \_\_\_\_\_

Concurrent meds \_\_\_\_\_

Patient's first name \_\_\_\_\_ Last name \_\_\_\_\_ Middle initial \_\_\_\_\_ Date of birth \_\_\_\_\_

Prescriber's first name \_\_\_\_\_ Last name \_\_\_\_\_ Phone \_\_\_\_\_

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Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Carbaglu® (carglumic acid)	200mg tablet	<b><u>Acute hyperammonemia due to NAGS deficiency:</u></b> Recommended initial pediatric and adult dosage is 100mg/kg/day to 250mg/kg/day divided into 2 to 4 doses and rounded to the nearest 100mg (i.e. half of Carbaglu tablet). Titrate based on plasma ammonia level and clinical symptoms.	Quantity of bottles _____ (60 tablets per bottle)
		<b><u>Maintenance for chronic hyperammonemia due to NAGS deficiency:</u></b> Recommended pediatric and adult maintenance dosage is 10mg/kg/day to 100mg/kg/day divided into 2 to 4 doses and rounded to the nearest 100mg (i.e. half of Carbaglu tablet). Titrate to target plasma ammonia level for age.	Refills _____
		<b>Prescribed dose:</b> Total daily dose is _____ g; equaling _____ tablets per day (to be divided into 2–4 doses per day).	Quantity of bottles _____ (5 tablets per bottle)
		Mix _____ 200mg tablets in a minimum of 2.5mL of water per tablet and drink immediately before meals or feedings. Take this dose _____ times per day.	Refills _____
		Do not swallow the tablets whole or crushed. Refrigerate until first use, then store at room temperature up to one month (see full PI for more information).	
Additional special instructions: _____			

**ATTENTION:** If this is an emergency (STAT) order OR for a hospital inpatient order for patients with acute hyperammonemia due to NAGS deficiency, propionic acidemia (PA) or methylmalonic acidemia (MMA), please call 877.900.9223. This form is for non emergency maintenance prescriptions only.

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

Your signature on this prescription authorizes the specialty pharmacy to dispense needed ancillary supplies for enteral administration of this medication, such as oral syringes.

**Prescriber's signature required (sign below)    (Physician attests this is his/her legal signature. NO STAMPS)**

SIGN HERE

Date

Dispense as written

Date

Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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