

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

To reach your team, call toll-free 808.650.6488.

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Prescription & Enrollment Form

sapropterin dihydrochloride

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 _____

Provider will read the following statement: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

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): _____

NKDA Known drug allergies _____

Concurrent meds _____

Pre-treatment PHE level _____ Date _____ Most recent PHE level _____ Date _____

Therapies/dietary phenylalanine restrictions during most recent PHE level _____

As applicable, please attach copies of prescriber's current assessment of disease control, including dietary management, dietary tolerance and/or pertinent labs.

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
sapropterin dihydrochloride	100mg tablets 100mg powder for oral use 500mg powder for oral use	<p>Take _____ of 100mg sapropterin dihydrochloride (tablet) once daily with meal, for a total dose of _____ mg/day.</p> <p>Total mg/kg prescribed _____</p> <p>Patient weight _____ Date _____</p> <p>Take _____ of 500mg sapropterin dihydrochloride powder packets and _____ of 100mg sapropterin dihydrochloride powder packets once daily with meal, dissolved or mixed as per package labeling, for a total dose of _____ mg/day.</p> <p>Total mg/kg prescribed _____</p> <p>Patient weight _____ Date _____</p> <p>Other _____</p>	30-day supply 90-day supply Other _____ Refills _____

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

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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