Please fax all pages of completed form to your 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 to log in or get started.

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	☐ Take _____ of 100mg sapropterin dihydrochloride (tablet) once daily with meal, for a total dose of _____ mg/day. Total mg/kg prescribed _____ Patient weight _____ Date _____ ☐ 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. Total mg/kg prescribed _____ Patient weight _____ Date _____ ☐ Other _____	☐ 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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