Prescription & Enrollment Form

nitisinone capsules

accredo®

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient first name _____

Last name _____ Middle initial _____

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 _____

Patient's primary language: ❑ English ❑ Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____

Insured's name _____

Insured's employer _____ Relationship to patient _____

Identification # _____ Policy/group # _____

Prescription card: ❑ Yes ❑ No If yes, carrier _____

Policy # _____ Group # _____

Is patient eligible for Medicare? ❑ Yes ❑ No

Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Prescriber's first name _____ Last name _____

Prescriber's title _____

If NP or PA, under direction of Dr. _____

Office contact and title _____

Office contact e-mail _____

Office/clinic/institution name _____

Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI # _____ License # _____

Deliver product to patient's home.

3 CLINICAL INFORMATION

Primary ICD-10 code: _____

Baseline ammonia level _____ **umol/L** Test date _____

Patient wt _____ kg Date wt obtained _____

Clinical impression _____

❑ NKDA ❑ Known drug allergies _____

Concurrent meds _____

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ nitisinone capsules	❑ 2 mg capsules ❑ 5 mg capsules ❑ 10 mg capsules	Take the following dose in the morning by mouth: _____ 2 mg capsules _____ 5 mg capsules _____ 10 mg capsules Take the following dose in the evening by mouth: _____ 2 mg capsules _____ 5 mg capsules _____ 10 mg capsules *Take doses at least one hour before or two hours after a meal.* Total daily nitisinone dose to equal _____ mg/kg/day. Divide dose _____ time(s) per day.	Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
Additional special instructions: _____			
❑ Other _____ _____ _____			❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____

ATTENTION: If this is an emergency (STAT) order OR for a hospital inpatient, please call 877.900.9223. This form is for non-emergency maintenance prescriptions only.

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

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

PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____

Date Substitution allowed Date Dispense as written

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. I authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

Please fax completed form to the team at 888.454.8488

To reach your team, call toll-free 888.454.8860.

You can now track shipments for all your Accredo patients.
Go to https://prescribers.accredo.com and click "Help" to register.