Please fax both pages of completed form to your Carbaglu team at 888.454.8488.

To reach your team, call toll-free 888.454.8860.

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

Carbaglu® (carglumic acid)—for oral use

accredo®

Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

Patient's first name _____ Last name _____ Middle initial _____

❑ Male ❑ Female Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ E-mail address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ E-mail 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 _____

Prescriber's first name _____ Last name _____

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

Office contact and title _____

Office contact phone number _____ Office contact e-mail _____

Office/clinic/institution name _____ Clinic/hospital affiliation _____

Street address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____ NPI # _____ License # _____

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic Clinic location _____

3 Clinical Information

Primary ICD-10 code: _____

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 _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ Carbaglu® (carglumic acid)	200mg tablet	***Acute hyperammonemia due to NAGS deficiency:*** *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.* ***Maintenance for chronic hyperammonemia due to NAGS deficiency:*** *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.* **Prescribed dose:** Total daily dose is _____ g; equaling _____ tablets per day (to be divided into 2–4 doses per day). 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. 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).	❑ Quantity of bottles _____ (60 tablets per bottle) Refills _____ ❑ Quantity of bottles _____ (5 tablets per bottle) Refills _____
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: ENFit® adapters, oral syringes, cassettes, administration sets, and tubing.

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

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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