accredo®

Prescription & Enrollment Form

sapropterin dihydrochloride

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's 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) _____
Cell phone _____
Other 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: ❑ Office ❑ Patient's home ❑ Clinic
Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____

❑ 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.

4 PRESCRIBING INFORMATION

Medication	Strength/Formulation	Directions	Quantity/Refills
❑ sapropterin dihydrochloride	❑ 100mg tablets ❑ 100mg powder for oral use ❑ 500mg powder for oral use	**Tablets** ❑ Take _____ of 100mg sapropterin dihydrochloride (tablet) once daily with meal, for a total dose of _____ mg/day. Total mg/kg prescribed _____ Patient weight _____ Date _____ **Packets** ❑ 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.

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

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

PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____
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.

Please fax completed form to your drug therapy team at 888.454.8488. To reach your team, call toll-free 844.492.4944.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.