Orsini Specialty Pharmacy

Fax: 877.848.6579 **Phone:** 800.764.0147

TIOPRONIN PATIENT ENROLLMENT

1 PATIENT INFORMATION

(Please complete the following information)

☐ **Please attach demographic information**

Patient Name (First, MI, Last): _____ DOB: _____ Gender: ◯ Male ◯ Female

Address: _____ City: _____ State: _____ Zip: _____

Patient Phone Number: _____

Parent/Caregiver Name (First, MI, Last): _____ Parent/Caregiver Phone Number: _____

2 INSURANCE INFORMATION

☐ **Please attach front and back of patient's insurance card, prescription card, and/or Medicaid card.**

Primary Insurance Name: _____

Primary Insurance ID: _____

Insurance Phone Number: _____

Policyholder Name: _____

Secondary Insurance Name: _____

Primary Insurance ID: _____

Insurance Phone Number: _____

Policyholder Name: _____

3 CLINICAL INFORMATION

☐ **Please fax clinical documentation to pharmacy along with referral form.**

Primary ICD-10 Code: _____ Secondary ICD-10 Code: _____

◯ NKDA ◯ Drug Allergies _____

Patient Weight: _____ ◯ lb ◯ kg Patient Height: _____ Ft _____ In

Concurrent Medications: _____

_____

4 PRESCRIBER INFORMATION

Practice Name: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Phone: _____ Fax: _____

5 PRESCRIPTION INFORMATION

Tiopronin tablets 100 mg

◯ May Substitute ◯ Dispense as Written:

◯ Adult Recommended Initial Dose: 800 mg/day OR

◯ Pediatrics (Weight ≥ 20 kg): 15 mg/kg/day OR

◯ Take: _____ tablets _____ times/day OR

☐ Take with food Dispense 30 day supply

◯ Alternative Dosing: _____

◯ Alternative Dosing: _____

◯ Alternative Directions: _____

◯ Refills: _____

Physician's Signature Date of Signature

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