Orsini
Rare Disease Pharmacy Solutions

Fax: 877.765.6254 **Phone:** 800.605.1524

DEFLAZACORT 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.**

ICD-10 Diagnosis Code: ☐ G71.01 Duchenne Muscular Dystrophy ☐ Other ICD-10 Code: _____

○ NKDA ○ Drug Allergies _____

Patient Weight: _____ ○ lb ○ kg Date Weight Obtained: _____ Date of Last Clinic Visit: _____

4 PRESCRIBER INFORMATION

Practice Name: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

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

Office Contact: _____ Phone: _____ Fax: _____

5 PRESCRIPTION INFORMATION

Deflazacort (Recommended dose: 0.9 mg/kg/day)

Directions for use: Check one option

☐ Deflazacort Tablets (6mg, 18mg, 30mg, 36mg)

☐ Deflazacort Oral Suspension (22.75mg/mL)

Dose: Choose one

○ Take 0.9 mg/kg orally once daily

○ Take _____ mg orally once daily

○ Other Directions _____

Dispense: 30 Day Supply **Refills:** 1 year

6 PHYSICIAN SIGNATURE (Required)

X _____ _____ X _____ _____

PRODUCT SUBSTITUTION PERMITTED | DATE OF SIGNATURE | DISPENSE AS WRITTEN | DATE OF SIGNATURE