Orsini Specialty Pharmacy

Fax: 877.369.3806 **Phone:** 800.837.8905

OLPRUVA™ PATIENT ENROLLMENT

(sodium phenylbutyrate)

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:
- ☐ E72.29 (Carbamylphosphate synthetase)
- ☐ E72.23 (Citrullinemia / ASS1)
- ☐ Other ICD-10: ______
- ☐ E72.4 (Ornithine transcarbamylase)
- ☐ E72.20 (Disorder of urea cycle metabolism, unspecified)

◯ NKDA ◯ Drug Allergies ______

Currently being treated with a nitrogen scavenger? ◯ Yes ◯ No If yes, which one? ______

Patient Body Surface Area (BSA): ______ m^2 Patient Weight: ______ ◯ lb ◯ kg Patient Height: ______ ◯ cm ◯ in

4 PRESCRIBER INFORMATION

Practice Name: ______

Prescriber Name: ______ Specialty: ______ NPI: ______

Address: ______ City: ______ State: ______ Zip: ______

Office Contact: ______ Phone: ______ Fax: ______

5 PRESCRIPTION INFORMATION

Olpruva (Recommended dose: 9.9 - 13 g/m²/day) ◯ May Substitute ◯ Dispense as Written

Total Daily Olpruva Dose: ______ g/day

Dosing Frequency: Choose either TID or Other Dosing (on label dosing is three (3) to six (6) divided doses per day)

◯ TID: Take ______ grams by mouth 3 times per day with food

◯ Other Frequency: Take ______ grams by mouth ______ times per day with food

Dosage Form: Check preferred option(s)

☐ 2-g dose envelopes ☐ 3-g dose envelopes ☐ 4-g dose envelopes ☐ 5-g dose envelopes ☐ 6-g dose envelopes ☐ 6.67-g dose envelopes

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

Physician's Signature ______ Date of Signature ______

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by the express authority of the sender to the named addressee.

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