Orsini
Rare Disease Pharmacy Solutions

Fax: 888.668.2143 **Phone:** 888.668.4198

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/m^2/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 _____