

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): _____ m² 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.