Orsini
Rare Disease Pharmacy Solutions

Fax: 877-299-8203 **Phone:** 773-598-6135

SAPROPTERIN 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: _____ Patient Email: _____

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: ☐ E70.0 Classical Phenylketonuria ☐ Other ICD-10 Code: _____

○ NKDA ○ Drug Allergies _____

Baseline Blood Phe Level: _____ Date Measured: _____ Patient Weight: _____ ○ lb ○ kg

Concomitant Meds: _____ Date Weight Obtained: _____

4 PRESCRIBER INFORMATION

Practice Name: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

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

Office Contact: _____ Phone: _____ Fax: _____

5 PRESCRIPTION INFORMATION

☒ **Sapropterin dihydrochloride 100mg Tablets** **NDC: 59651-0574-08**

Sapropterin dose per kg body weight: ☐ **10mg/kg** ☐ **20mg/kg** ☐ **Other:** _____**mg/kg**

Directions for use:

☐ Take _____ 100mg tablets once daily as directed with a meal for a total dose of _____ mg/day

☐ Other Direction: _____

Dispense: 30 Day Supply **Refills:** ☐ 1 year ☐ Other: _____

6 PHYSICIAN SIGNATURE (Required)

X _____ _____ X _____ _____

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