

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: _____	Secondary Insurance Name: _____
Primary Insurance ID: _____	Primary Insurance ID: _____
Insurance Phone Number: _____	Insurance Phone Number: _____
Policyholder Name: _____	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

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