KYMBEE™ (deflazacort) Tablets

Upsher-Smith *Promise of Support*® Program

PRESCRIPTION FORM

Fax: 847-423-6222 | **Phone:** 847-849-1551

1 – PATIENT INFORMATION

☒ **Please attach demographic information.**

Patient Name (First, MI, Last):_____ DOB:_____ Gender: ☐ Male ☐ Female

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

Patient/Caregiver Phone Number: _____

Parent/Caregiver Name (First, MI, Last): _____

2 – INSURANCE INFORMATION

☒ **Please attach front and back of patient's insurance card, prescription card, and/or Medicaid card.** ☐ **Patient has no insurance.**

Primary Insurance Name: _____

Member ID: _____

Group ID: _____

PCN: _____ BIN: _____

Insurance Phone Number: _____

Policyholder Name: _____

Relationship to Patient: _____

Secondary Insurance Name: _____

Member ID: _____

Group ID: _____

PCN: _____ BIN: _____

Insurance Phone Number: _____

Policyholder Name: _____

Relationship to Patient: _____

3 – CLINICAL INFORMATION

☒ **Please fax clinical documentation to pharmacy along with referral form.**

☐ New to deflazacort therapy ☐ Current deflazacort patient ☐ Patient has tried prednisone for more than 6 months

ICD-10 Diagnosis Code: ☐ G71.01 Duchenne Muscular Dystrophy ☐ Other ICD-10 Code: _____

☐ NKDA ☐ Drug Allergies: _____

Patient Weight: _____ ☐ lb ☐ kg Date Weight Obtained: _____ Date of Last Clinic Visit: _____

4 – PRESCRIBER INFORMATION

Practice Name: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

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

Office Contact: _____ Phone: _____ Fax: _____

5 – PRESCRIPTION INFORMATION

KYMBEE™ (deflazacort) Tablets (Recommended dose: 0.9 mg/kg/day)

Tablet strength: Check one option

☐ KYMBEE™ (deflazacort) Tablets 6 mg | NDC 0245-0814-11

☐ KYMBEE™ (deflazacort) Tablets 18 mg | NDC 0245-0815-30

☐ KYMBEE™ (deflazacort) Tablets 30 mg | NDC 0245-0816-30

☐ KYMBEE™ (deflazacort) Tablets 36 mg | NDC 0245-0817-30

Directions for use: Check one option

☐ Take 0.9 mg/kg orally once daily

☐ Take _____mg orally once daily

☐ Other Directions:

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

Prescriber's Signature: Physician attests this is his/her signature.

X _____ X _____

DAW Signature* / Date Substitution Permitted / Date

*Certain states require "brand medically necessary" or other language to be handwritten by the prescriber if he/she has made this determination in his/her independent clinical judgment. Certain states require the use of ePrescribing. **Note:** The prescriber should comply with state-specific prescription requirements. Noncompliance could result in outreach to the prescriber. All Program terms and conditions apply. 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.

UPSHER-SMITH