All required fields (marked with *) and signatures must be completed before submitting this form by fax or email.
Fax referral to: 1-888-668-2143 | Email referral to: AmplifyAssist@orsinihc.com
Call AmplifyAssist at 888-668-4198 for more information | Hours: 8 am–6 pm CT, Monday–Friday

AmplifyAssist™ Enrollment Form

AmplifyAssist™ MIPLYFFA® arimoclomol capsules

1. PATIENT INFORMATION

*First Name: _____ Middle Initial: _____ *Last Name: _____ Date of Birth: ____/____/____

Gender: ☐ Male ☐ Female ☐ Other: _____ (Please provide for identification purposes.)

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

*Primary Phone Number: _____ ☐ Home ☐ Mobile Best Time to Call: ☐ AM ☐ PM ☐ No preference

Email Address: _____ Preferred Method of Communication: ☐ Phone ☐ Text ☐ Email

Address: _____ City: _____ State: ____ Zip Code: _____

Representative/Caregiver Name: _____ Relationship to Patient: _____ Same Contact Info as Patient: ☐ Yes ☐ No

*Primary Phone Number: _____ ☐ Home ☐ Mobile Best Time to Call: ☐ AM ☐ PM ☐ No preference

2. CLINICAL INFORMATION

*Primary Diagnosis Code: ☐ Please see attached clinical information for the information requested below.

☐ E75.24 = Niemann-Pick disease ☐ E75.242 = Niemann-Pick disease type C

☐ E75.249 = Niemann-Pick disease, unspecified ☐ Other: _____

NPC Management-please document prior & current therapies below:

Prior/current therapies: ☐ Miglustat (☐ Current ☐ Prior) ☐ Aqneursa (☐ Current ☐ Prior)

☐ Other (Include investigational therapies the patient may be on): _____ (☐ Current ☐ Prior)

Has the patient had confirmatory genetic testing for NPC ☐ Yes ☐ No Diagnosis Date: _____ Time to Treatment from Diagnosis: _____

Age for Onset of Symptoms: _____

Signs/Symptoms patient is experiencing:

Is the patient ambulatory? ☐ Yes ☐ No Is the patient experiencing severe dystonia? ☐ Yes ☐ No Is the patient experiencing dysphagia? ☐ Yes ☐ No

Is the patient on a G-tube? ☐ Yes ☐ No Is the patient verbal? ☐ Yes ☐ No

☐ Other: _____ **Please provide clinical history/documentation as part of your submission.**

3. INSURANCE INFORMATION (PLEASE PROVIDE FRONT AND BACK COPY OF INSURANCE CARD(S))

Primary Insurance ☐ Commercial ☐ Medicare ☐ Medicaid

Insurance Carrier Name: _____

Phone Number: _____

Employer Grp/Issuer if available: _____

Phone Number: _____

ID#: _____ Group#: _____

Prescription Carrier Name: _____

ID#: _____ Group#: _____

Bin#: _____ PCN#: _____

Primary Cardholder Name: _____

Secondary Insurance ☐ Commercial ☐ Medicare ☐ Medicaid

Insurance Carrier Name: _____

Phone Number: _____

Employer Grp/Issuer if available: _____

Phone Number: _____

ID#: _____ Group#: _____

Prescription Carrier Name: _____

ID#: _____ Group#: _____

Bin#: _____ PCN#: _____

Primary Cardholder Name: _____

4. OFFICE AND PRESCRIPTION INFORMATION

***Prescriber First Name:** _____ ***Last Name:** _____

***Institution/Hospital Name:** _____ ***NPI:** _____

***Address:** _____ ***City:** _____ ***State:** ____ ***Zip Code:** _____

***Phone:** _____ ***Ext:** _____ ***Fax#:** _____

***Office Contact Completing This Form:** _____ ***Email:** _____

***Recommended Dosing Guidelines:** Please see **Prescribing Information** for dosing considerations in special populations.

Patient Body Weight		Recommended Dosage
8-15 kg	17.6-33 lb	47 mg three times a day
>15-30 kg	>33-66 lb	62 mg three times a day
>30-55 kg	>66-121 lb	93 mg three times a day
>55 kg	>121 lb	124 mg three times a day

Product capsules may be swallowed whole or the contents of the capsule can be added to a suitable beverage, soft food, or added to water to allow administration via a feeding tube.

***Patient Weight** _____ **kg or** _____ **lb**

***Prescription:**

☐ 47 mg (NDC: 72542-147-01)

☐ 62 mg (NDC: 72542-162-01)

☐ 93 mg (NDC: 72542-193-01)

☐ 124 mg (NDC: 72542-124-01)

☐ Other: _____

Number of bottles (90 capsules per bottle): 1

Days supply: 30 Days

***Refill:** _____ Times

***SIG:**

☐ Take one capsule by mouth three times daily

☐ Other: _____

***Prescriber Signature (Dispense as written):** _____ ***Date:** _____

***Prescriber Signature (Substitution permitted):** _____ ***Date:** _____

I certify that I have prescribed MIPLYFFA as described above based on my professional judgment of medical necessity. I authorize the release of medical and/or other patient information relating to MIPLYFFA therapy to Zevra Therapeutics, Inc., its agents, and Service Providers (including, but not limited to, MIPLYFFA-dispensing pharmacies) to use and disclose as necessary for prior authorization processing and fulfillment of the prescription.