CYCLE PHARMA

Nityr® nitisinone Tablets

☐ **URGENT – NEWBORN PRESCRIPTION**
(CHECK HERE IF THIS IS A PRESCRIPTION FOR A NEWBORN BABY)

Phone: 1-800-847-8714
Fax this form: 1-800-842-5163
www.nityr.us

ENROLLMENT FORM FOR NITYR® (NITISINONE) TABLETS

The NITYR® Patient Support Program is a program that helps patients prescribed NITYR® access their medication. Complete the form to help your patients get started on treatment.

This form is also available electronically at: www.nityr.us

PATIENT INFORMATION & SHIPPING INFORMATION – Please fill out completely

Patient's Full Name (First, Middle initial and Last name):		**Date of Birth:**	
Sex: ◯ Female ◯ Male	Language: ◯ English ◯ Spanish ◯ Other:		
Parent/Guardian name (*if applicable*):		Relationship:	
Patient's Address:			
Suite/Floor/Apt #:	City:	State:	Zip:
Cell Phone:	Home Phone/Other:	E-mail:	

INSURANCE INFORMATION - check one box and fax copies of all insurance cards (front and back)

◯ ACTIVE INSURANCE ◯ PATIENT HAS NO INSURANCE COVERAGE ◯ NEWBORN PATIENT

PRIMARY INSURANCE		SECONDARY INSURANCE (optional)	
Primary Insurance Name:		Secondary Insurance Name:	
Insurance Phone Number:		Insurance Phone Number:	
Subscriber:		Subscriber:	
Relationship to Patient:		Relationship to Patient:	
Member ID:	Group ID:	Member ID:	Group ID:
Employer:		Employer:	

MEDICAL INFORMATION AND TREATMENT HISTORY – Please fill out completely and fax all pertinent clinical and lab information

PRIMARY DIAGNOSIS:		Diagnosis Code (ICD-10):	
Patient is currently on a tyrosine and phenylalanine restricted diet? ◯ Yes ◯ No - If no, provide reason:			
Liver transplanted: ◯ Yes ◯ No - If yes, provide transplant date:			
Comorbidities:			
List the names of other medications the patient is taking:			
Patient Allergies? ◯ NKDA ◯ Known	If known please list:		

ENROLLMENT FORM FOR NITYR® (NITISINONE) TABLETS

PRESCRIPTION (for Use by In-Network Specialty Pharmacy)

Patient's Full Name (First, Middle initial and Last name): **Date of Birth:**

Patient Weight: ◯ kg ◯ lbs

Ship to: Prescriber's Office or Hospital Pharmacy: ◯ First Fill ◯ Always ◯ Never

The " Quick Start" is a FREE supply of NITYR® that allows eligible patients to begin therapy immediately while the NITYR® Patient Support Program secures appropriate benefit verifications and authorizations. If Quick Start is selected for the patient, an initial 14-day supply of NITYR® will be dispensed (28-day initial supply for patients 6 months of age and younger). The strength, directions and quantity will match per written below for the Ongoing Prescription. All further quick start deliveries will be supplied in 14-day refills (with a limit of 56 days of FREE supply).

☐ **"Quick Start"** (Please check box if the above statement applies)

NITYR® Tablets ☐ **Ongoing Prescription** (Please check "Ongoing Rx" box for continuous, refillable supply of Nityr, and check box/sign for each prescribed Strength/NDC)

☐ 2mg NITYR® Tablets	☐ 5mg NITYR® Tablets	☐ 10mg NITYR® Tablets
Directions: AM PM	Directions: AM PM	Directions: AM PM
Quantity: Refills:	Quantity: Refills:	Quantity: Refills:
Date:	Date:	Date:
Dispense as Written: X Prescriber's Signature	**Dispense as Written:** X Prescriber's Signature	**Dispense as Written:** X Prescriber's Signature
OR	OR	OR
Substitution Allowed: X Prescriber's Signature	**Substitution Allowed:** X Prescriber's Signature	**Substitution Allowed:** X Prescriber's Signature

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

PATIENT ADMINISTRATION DIRECTIONS

Morning	Patient CAN swallow tablets	Patient CANNOT swallow tablets	
____ 2mg tablet(s) and ____ 5mg tablet(s) and ____ 10mg tablet(s)	☐ Take tablets with or without food	☐ Suspend in an oral syringe (SUSPENSION) Create a suspension using an oral syringe with ____mL* of water. Follow Instructions For Use. Oral syringes will be provided. ** use 2.6mL for 1 tablet or 5mL for 2 tablets*	☐ Crushed and mixed with applesauce Crush tablet(s), mix with applesauce and administer. Follow Instructions for use. A tablet crusher will be provided.
Evening			
____ 2mg tablet(s) and ____ 5mg tablet(s) and ____ 10mg tablet(s)			

Other:

PRESCRIBER INFORMATION

Prescriber's Name and Last Name: NPI: E-mail:

Practice/Hospital Name: Practice/Hospital Department:

Practice/Hospital Address: City: State: Zip:

Office Contact: Phone: Extension: Alternate Phone: Fax:

R. Dietitian: Phone: Extension: Alternate Phone: Fax:

Prescriber Declaration: I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed NITYR® based on my professional judgment of medical necessity. I authorize Cycle Pharmaceuticals or its affiliated companies or subcontractors, including in-network specialty pharmacies, through the NITYR® Patient Support Program ("the Program") to forward this prescription electronically, by facsimile, or by mail to the relevant in-network pharmacy for the above-named patient. I also authorize the Program to perform any steps necessary to obtain reimbursement for NITYR®, including but not limited to insurance verification and case assessment. I understand that the Program may need additional information, and I agree to provide it as needed for the purposes of reimbursement. I also authorize the Program to perform any steps necessary to obtain reimbursement for NITYR®, including but not limited to insurance verification, case assessment and necessary steps to facilitate coverage decision. Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

X
Prescriber's Signature

Date

RESET FORM