

Diplomat is the exclusive pharmacy services provided for the distribution of NityrTM and the fulfillment of the NityrTM Patient Support Program in the United States

Patient Information **Prescriber + Shipping Information**

| | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Patient name: _____ DOB: _____ Sex: Female Male SSN: _____ Language: _____ Wt: _____ kg lbs Ht: _____ cm in Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Phone: _____ Alternate: _____ Caregiver name: _____ Relation: _____ Local pharmacy: _____ Phone: _____ Insurance plan: _____ Plan ID: _____ Please fax a copy of front and back of the insurance card(s). | Prescriber name: _____ NPI: _____ Address: _____ Apt/Suite: _____ City: _____ State: _____ Zip: _____ Contact: _____ Phone: _____ Alternate: _____ Fax: _____ Email: _____ If shipping to prescriber: First Fill Always Never |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Clinical Information (Please fax all pertinent clinical and lab information)

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: _____

| Current Therapy | Yes | No | Reason for Discontinuation of Therapy | Approximate Start Date | Approximate End Date |
|-------------------------------|-----|----|---------------------------------------|------------------------|----------------------|
| Orfadin 0.5 mg/kg twice daily | | | _____ | _____ | _____ |
| Orfadin 0.5 mg/kg once daily | | | _____ | _____ | _____ |
| _____ | | | _____ | _____ | _____ |

Comorbidities: _____
 Concomitant Medications: _____
 Allergies: NKDA Other: _____

Prescription

Quick Start is a FREE 14-day supply of NITYRTM that will allow eligible patients to begin therapy while the specialty pharmacy, Diplomat, secures appropriate benefit verifications and authorizations. If a Quick Start is selected to be dispensed for the patient, the strength, directions and quantity will match per written below for the commercial prescription along with refill limit of 3 (total of 4 fills), as applicable per patient.

| Quick Start | Commercial | Drug Name & Strength | Directions | Qty | Refills |
|-------------|------------|------------------------------------------------|------------|-------|---------|
| | | Nityr TM (nitisinone) tablets 2 mg | _____ | _____ | _____ |
| | | Nityr TM (nitisinone) tablets 5 mg | _____ | _____ | _____ |
| | | Nityr TM (nitisinone) tablets 10 mg | _____ | _____ | _____ |

Ancillary Supplies

Oral Syringes (Appropriate quantity will be determined upon interaction with patient/caregiver.)
 Pill Crusher

[Prescribing Information](http://www.nityr.us/PI) is available at www.nityr.us/PI

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Patient/Caregiver's Signature: _____ Date: _____
I authorize Diplomat Pharmacy, Inc. to share my health and contact information, including my email address, with other entities who provide healthcare services to me, or who can provide additional therapy or nutrition support.

Prescriber's Signature: _____ Date: _____
I authorize Diplomat Pharmacy, Inc. and its representatives to act on behalf of Cycle Pharmaceuticals as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA) if you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately by calling 810.768.9178 or by emailing compliance@diplomat.is to obtain instructions as to the proper destruction of the transmitted material. Thank you. 071117 - Job code: US-0072, date of preparation: July 2018

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