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 (PAGE 1 OF 2)

Diplomat is the exclusive pharmacy services provider for the distribution of NITYR™ and the fulfilment of the NITYR™ Patient Support Program in the United States.

PATIENT INFORMATION & SHIPPING INFORMATION – Please fill out completely

Patient's name: DOB:

Parent/Guardian name (*if applicable*): Relation:

Sex: ◯ Female ◯ Male

Language: ☐ English ☐ Spanish ☐ Other:

Patient's Address:

Suite/Floor/Apt: City: State: Zip:

Home Phone: Cell Phone/Other:

If shipping to prescriber/Hospital pharmacy: ◯ First Fill ◯ Always ◯ Never

INSURANCE INFORMATION - check one box and fax copies of the insurance card (front and back)

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

PRIMARY INSURANCE	SECONDARY INSURANCE
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:

Is the Patient currently receiving nitisinone treatment? Yes ◯ No - If yes, complete details below:

☐ Orfadin* (nitisinone)	☐ capsules - Dose:	◯ once daily ◯ twice daily
	☐ suspension - Dose:	◯ once daily ◯ twice daily

Reasons for discontinuation of Orfadin treatment:

Comorbidities:

List the names of other medications the patient is taking:

Patient Allergies? ◯ NKDA ◯ Known If known please list:

*Orfadin is a registered trademark licensed by Sobi, Inc. or its affiliates.

Enrollment form for NITYR™ (nitisinone) tablets (PAGE 2 OF 2)

PATIENT NAME:

PATIENT DATE OF BIRTH:

PRESCRIPTION

The Quick Start is a FREE supply of NITYR™ that will allow eligible patients to begin therapy immediately, while the specialty pharmacy, Diplomat, secures appropriate benefit verifications and authorizations. If a Quick Start is selected for the patient, an initial 14-day supply of Nityr will be dispensed **(28-day initial supply for patients < or equal to 6 months of age)**. The strength, directions and quantity will match per written below for the commercial prescription. All further quick start deliveries will be supplied in 14-day refills (with a limit of 56 days of FREE supply per patient).

Patient Weight:_____ ◯ kg ◯ lbs

Quick Start	Commercial	Drug Name	Strength	Dose (total number of mg per day)	Quantity (total number of tablets for 30 days' supply)	Refills
☐	☐	NITYR™ tablets	☐ 2mg			
			☐ 5mg			
			☐ 10mg			

Directions for use for patients that can swallow tablets

Morning	Administration
____ 2mg tablet(s) and ____ 5mg tablet(s) and ____ 10mg tablet(s) and	Take tablets with or without food.
Evening	**Administration**
____ 2mg tablet(s) and ____ 5mg tablet(s) and ____ 10mg tablet(s) and	Take tablets with or without food.

☐ Other:

Directions for use for patients that <u>cannot</u> swallow tablets

Morning	Administration (please tick one)	
____ 2mg tablet(s) and ____ 5mg tablet(s) and ____ 10mg tablet(s) and	☐ **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	**Administration (please tick one)**	
____ 2mg tablet(s) and ____ 5mg tablet(s) and ____ 10mg tablet(s) and	☐ **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.

Other:

PRESCRIBER INFORMATION

Prescriber Name:	NPI:			
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:

By signing the below, 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.

Prescriber's Name (please print): **Prescriber Signature (required):** **Date:**

RESET FORM