



NityrTM nitisinone Tablets

Phone: 844-767-5865
Fax this form: 855-282-0724
www.nityr.us

NITYRTM 21-Day Free Trial Program*

Enrollment Form for NITYR TM (nitisinone) tablets FREE TRIAL (PAGE 1 OF 2)			
EnvoyHealth is the service provider for the 21-DAY FREE TRIAL PROGRAM of NITYR TM 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:	
Shipping free trial to prescriber/Hospital pharmacy:		Yes	No
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. *The 21-DAY FREE TRIAL PROGRAM is subject to terms and conditions, eligibility criteria and applicable state and federal laws. Eligible patients can try NITYR tablets for 21 days for free as long as their doctor prescribes it. For full terms and conditions please visit: www.nityr.us/offertcs

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

PATIENT NAME:

PATIENT DATE OF BIRTH:

PRESCRIPTION FOR THE 21-DAY FREE TRIAL OFFER*

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Patient Weight: _____ kg lbs

21-DAY FREE TRIAL	Drug Name	Strength	Dose (total number of mg per day)	Quantity (total number of tablets for 21 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 cannot 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 EnvoyHealth 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 EnvoyHealth.

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

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

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