CYCLE PHARMA

Nityr™
nitisinone
Tablets

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

NITYR™ 21-Day Free Trial Program*

Enrollment Form for NITYR™ (nitisinone) tablets FREE TRIAL (PAGE 1 OF 2)

EnvoyHealth is the service provider for the 21-DAY FREE TRIAL PROGRAM of NITYR™ 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 <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 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:**

RESET FORM