Nityr® nitisinone Tablets

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

30-DAY FREE NITYR® PROGRAM

Patients can try NITYR for 30 days, one time, for free, as long as their doctor prescribes it. Subject to terms and conditions, eligibility criteria, and other federal and state law. Terms and Conditions and eligibility criteria are available at www.nityr.us/offerstcs.

Complete the form below to help your patients get started on treatment. All fields are required unless noted as optional. Copies of this form are 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

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:

Confidentiality Statement: This facsimile 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 and call 1.800.847.8714 to obtain instructions as to the proper destruction of the transmitted material.

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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: Yes No

NITYR® Tablets 30-Day Free NITYR® Program (Please check box and sign for each prescribed Strength/NDC)

2 2 mg NITYR® Tablets	5mg NITYR® Tablets	10mg NITYR® Tablets
Directions:__________AM___________PM	Directions:__________AM___________PM	Directions:__________AM___________PM
Quantity:____________ Refills: NO REFILLS	Quantity:____________Refills: NO FEFILLS	Quantity:____________ Refills: NO FEFILLS
(Quantity: total number of tablets for 30 days supply)	(Quantity: total number of tablets for 30 days supply)	(Quantity: total number of tablets for 30 days supply)
Date:_______________	Date:_______________	Date:_______________
X_________________________________ Prescriber's Signature	X_________________________________ Prescriber's Signature	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:

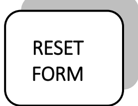
Office Contact: Phone: Extension: Alternate Phone: Fax:

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



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