☐ **URGENT – NEWBORN PRESCRIPTION**
(CHECK HERE IF THIS IS A PRESCRIPTION FOR A NEWBORN BABY)

NITYR® (nitisinone) Tablets Enrollment Form

Nityr® nitisinone Tablets

CYCLE PHARMA

Phone: +1 (888) 360-8482 (VITA) FAX: +1 (888) 385-8482 (VITA) Website: www.cyclevita.life | www.nityr.us

1. PATIENT INFORMATION

Patient Name (First, Last):	Date of Birth:		Gender:
Street Address:	City:	State:	ZIP:
Email Address:	Cell Phone:	Home Phone:	Preferred Language:
Caregiver Name (if applicable):	Relation to patient:	Caregiver Phone (if different from patient):	

2. INSURANCE INFORMATION *(attach front and back copies of all insurance cards)*

☐ **Patient/Family does NOT have insurance** ☐ **Patient is a NEWBORN**

Primary Insurance Company Name:	Primary Insurance Cardholder Name:	Relation to Patient:
Primary Insurance Policy Number:	Primary Insurance Group Number:	Primary Insurance Phone Number:
Pharmacy Plan Name:	PCN Number:	BIN Number:
Pharmacy Plan Policy Number:	Pharmacy Plan Group Number:	Pharmacy Phone Number:
Secondary Insurance Plan Name:	Secondary Insurance Cardholder Name:	Relation to Patient:
Secondary Insurance Policy Number:	Secondary Insurance Group Number:	Secondary Insurance Phone Number:

3. PRESCRIBER INFORMATION

Prescriber Name (First, Last):	Facility/Clinic Name:		
State Medical License Number:	NPI Number:		
Facility/Clinic Street Address:	City:	State:	ZIP:
Facility Shipping Address: ☐ Same as above	City:	State:	ZIP:
Prescriber Email:	Prescriber Phone Number:	Prescriber FAX:	
Dietitian or Office Contact Name (First, Last):	Dietitian or Office Contact Email:	Dietitian or Office Contact Phone Number:	

4. PATIENT MEDICAL INFORMATION

Primary Diagnosis:

Diagnosis Code: ☐ ICD-10: E70.21 (HT-1) ☐ ICD-10: E70.29 (AKU) ☐ Other:

Patient Weight: _____ ☐ kg ☐ lbs

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:

Allergies: ☐ NKDA ☐ Known:

Current Medications: ☐ None ☐ Known:

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Patient Name (Printed):	Date of Birth:

5. PRESCRIPTION

☐ **Preferred Specialty Pharmacy:** _____

Patient's Full Name (First, Middle Initial, Last):	Date of Birth:

Ship to: ☐ Prescriber's Office ☐ Hospital Pharmacy ☐ Patient Residence:
☐ First Fill ☐ Always ☐ Never

☐ **"Quick Start"** *(Please check this box if the below statement applies to this patient)*

"Quick Start" is a FREE supply of NITYR® (nitisinone) Tablets that allows eligible patients to begin therapy immediately while Cycle Vita™ secures appropriate benefit verification and authorization. If Quick Start is selected for the patient, an initial 14-day supply of NITYR® (nitisinone) Tablets will be dispensed; 28-day initial supply for patients 6 months and younger. The strength, directions and quantity will match the written prescription below. All further Quick Start deliveries will be supplied in 14-day refills (with a limit of 56 days of FREE supply).

☐ **Ongoing Prescription** *(Check this box for continuous, refillable supply of NITYR® (nitisinone) Tablets).* Please select the prescribed strength below.

☐ **2mg NITYR® (nitisinone) Tablets (NDC: 70709-002-60)**	☐ **5mg NITYR® (nitisinone) Tablets (NDC: 70709-005-60)**	☐ **10mg NITYR® (nitisinone) Tablets (NDC: 70709-000-60)**
Dosage Instructions: _____ AM _____ PM Quantity: _____ Refills: _____ Date: _____ Dispense as Written: x _____	Dosage Instructions: _____ AM _____ PM Quantity: _____ Refills: _____ Date: _____ Dispense as Written: x _____	Dosage Instructions: _____ AM _____ PM Quantity: _____ Refills: _____ Date: _____ Dispense as Written: x _____

The prescriber is to comply with their 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.

6. ADMINSTRATION INSTRUCTIONS

Morning	Patient CAN swallow tablet(s)	Patient CANNOT swallow tablets	
_____ 2mg tablet(s) and **_____ 5mg tablet(s) and** **_____ 10mg tablet(s) and**	☐ Take tablet(s) 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. **use 2.6mL for (1) tablet or 5mL for (2) tablets; an oral syringe will be provided*	☐ **Crush and mix with applesauce** Crush tablet(s)**, mix with applesauce and administer. Follow instructions for use. ***a tablet crusher will be provided*
Afternoon			
_____ 2mg tablet(s) and **_____ 5mg tablet(s) and** **_____ 10mg tablet(s) and**			

Special Instructions:

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® (nitisinone) Tablets 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 Cycle Vita™ – NITYR® (nitisinone) Tablets Program ("the Program") to forward this prescription 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® (nitisinone) Tablets, including but not limited to insurance verification and authorization. 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® (nitisinone) Tablets, including but not limited to insurance verification and authorization to facilitate a coverage decision. Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS.)

Prescriber Signature: X _____ Date: _____