



# NITYR® (nitisinone) Tablets Enrollment Form



Phone: +1 (888) 360-8482 (VITA) FAX: +1 (888) 385-8482 (VITA) Website: [www.cyclevita.life](http://www.cyclevita.life) | [www.nityr.us](http://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: <input type="checkbox"/> 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: <input type="checkbox"/> ICD-10: E70.21 (HT-1) <input type="checkbox"/> ICD-10: E70.29 (AKU) <input type="checkbox"/> Other:			
Patient Weight: _____ <input type="checkbox"/> kg <input type="checkbox"/> lbs		Patient is currently on a tyrosine and phenylalanine restricted diet?: <input type="checkbox"/> Yes <input type="checkbox"/> No *If no, provide reason:			
Liver transplanted?: <input type="checkbox"/> Yes <input type="checkbox"/> No *If yes, provide transplant date:					
Allergies: <input type="checkbox"/> NKDA <input type="checkbox"/> Known:					
Current Medications: <input type="checkbox"/> None <input type="checkbox"/> Known:					

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 (888) 360-8482 to obtain instructions as to the proper destruction of the transmitted material.

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Patient Name (Printed): _____	Date of Birth: _____
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**5. PRESCRIPTION**  Preferred Specialty Pharmacy: \_\_\_\_\_

Patient's Full Name (First, Middle Initial, Last): _____	Date of Birth: _____
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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 _____
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*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. ADMINISTRATION INSTRUCTIONS**

Morning	Patient CAN swallow tablet(s)	Patient CANNOT swallow tablets	
_____ 2mg tablet(s) and _____ 5mg tablet(s) and _____ 10mg tablet(s) and	<input type="checkbox"/> Take tablet(s) with or without food	<input type="checkbox"/> <b>Suspend in an oral syringe (SUSPENSION)</b> Create a suspension using an oral syringe with _____ mL* of water. Follow instructions for use.  <i>*use 2.6mL for (1) tablet or 5mL for (2) tablets; an oral syringe will be provided</i>	<input type="checkbox"/> <b>Crush and mix with applesauce</b> Crush tablet(s)***, mix with applesauce and administer. Follow instructions for use.  <i>**a tablet crusher will be provided</i>
<b>Afternoon</b>			
_____ 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: \_\_\_\_\_

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