



Patient Enrollment Form for HARLIKU™ (nitisinone) Tablets

Phone: 888 360-8482 FAX: 888 385-8482

harliku™
(nitisinone) Tablets

To Enroll, fax this form:
888 385-8482
Or email: hello@cyclevita.life

All required fields are purple and noted with an asterisk*

PATIENT INFORMATION	Patient Last Name*		Patient First Name*	
	Date of Birth*	Gender* ☐ Male ☐ Female ☐ Other		
	Caregiver Name (if applicable)		Relationship to Patient	
	Street Address*		Suite/Floor/Apt #	
	City*		State*	Zip code*
	Preferred Method of Contact (please specify)*: ☐ Cell Phone ☐ Alternate Phone ☐ Email			
	Language Preferred* ☐ English ☐ Spanish ☐ Other (please specify):			

INSURANCE INFORMATION	Please attach a copy of the prescription insurance benefit card, front and back, or complete the following* ☐ Prescription insurance benefit card attached ☐ Patient does not have insurance			
	Primary Insurance Company Name*		Secondary Insurance Company Name	
	Primary Insurance Company Phone Number*		Secondary Insurance Company Phone Number	
	Name of Primary Cardholder*		Name of Primary Cardholder	
	Primary Insurance Member ID*	Group ID*	Secondary Insurance Member ID	Group ID
	BIN*	PCN*	BIN	PCN
	Prior Authorization Status* ☐ Submitted ☐ Not Submitted ☐ Approved ☐ Denied			

PRESCRIBER INFORMATION	Prescriber Last Name*		Prescriber First Name*	
	Prescriber Office/Site/Clinic*			
	Prescriber Phone Number*		Prescriber Fax Number*	
	Prescriber Medicaid Number*		Prescriber Tax ID*	
	Street Address*			
	City*		State*	Zip Code*
	NPI Number*			
	Office Contact Name*			
Office Contact Phone Number with Extension*		Office Email Address*		

Patient Full Name*	Date of Birth*
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CLINICAL INFORMATION	Diagnosis ICD-10 code* ☐ E70.29 AKU ☐ Other (please specify): _____ Date of diagnosis _____	Baseline urine HGA levels <i>at diagnosis</i> (please include units): _____ _____
	I am prescribing HARLIKU, which is medically necessary for the following reason: ☐ To reduce urine HGA levels ☐ Other (please specify): _____ Additional comments: _____	
	Patient history with nitisinone* ☐ Has never been prescribed nitisinone ☐ Is currently prescribed generic nitisinone ☐ Is currently prescribed Brand nitisinone ☐ Other (please specify): _____	
	Patient Allergies* ☐ No Known ☐ Known (please list known allergies): _____ _____	
	Patient Medications* ☐ None ☐ Please list the names of other medications the patient is currently taking (if any): _____ _____	
	Patient Health Conditions* ☐ No Known ☐ Please list the name of any other health conditions the patient currently has (if any): _____ _____	
	Patient is currently on (or will be recommended) a protein controlled diet ☐ Yes ☐ No	

PRESCRIPTION INFORMATION	☐ HARLIKU (nitisinone) Tablets 2mg*	NDC Number: 70709-112-60
	Only prescriptions filled with the product NDC number listed above will be eligible for Cycle Vita (Eligible Programs)	
	Quantity: _____ Tablets	
	Per days supply: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other: _____	
	Number of Refill(s)* _____	
	Patient Directions (check all that apply)* ☐ Take one 2 mg HARLIKU (nitisinone) Tablet once a day with or without food, for a total dose of 2 mg/day. ☐ Other (please specify) _____ _____	
☐ Bridge Program* - "Bridge" is a FREE supply of HARLIKU (nitisinone) Tablets that allows patients with a valid prescription and commercial insurance (e.g., employer-sponsored insurance plans) to begin therapy immediately while appropriate benefit verification and authorization is identified. "Bridge" may also be requested for existing patients who are temporarily experiencing disruption in therapy due to insurance coverage. Patients covered by government insurance plans (e.g. Medicaid or Medicare) are not eligible for the Bridge Program. By checking the box above for Bridge, I, as the prescriber, with my signature below on this form, agree and attest that I will not submit a claim to or seek payment from the patient or any third-party payer for payment/reimbursement for any free HARLIKU (nitisinone) Tablet product(s). I agree and understand that any free HARLIKU (nitisinone) Tablet product(s) provided may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on this form. The Bridge program may be modified or terminated without notice at any time. *Bridge is at no cost, for eligible patients within labeled indication only, and not contingent on purchase of any kind. Bridge is intended to support continuation of prescribed therapy if there is any disruption in therapy due to insurance coverage.		

PRESCRIBER DECLARATION	Prescriber Declaration: I understand and agree that, as the prescriber, I will comply with my 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 me, as the prescriber. 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 HARLIKU (nitisinone) Tablets based on my professional judgment of medical necessity. I authorize Cycle Vita, its affiliates, agents, and contractors (collectively, "Cycle Vita") to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the above-named patient utilizing their benefit plan. I authorize Cycle Vita, its affiliates, agents and contractors to perform any steps necessary to secure reimbursement for HARLIKU (nitisinone) Tablets, including but not limited to insurance verification and case assessment. I understand that Cycle Vita may need additional information, and I agree to provide it as needed for the purposes of securing reimbursement.		
	Prescriber Signature (please select one of the options below)*		
	☒ _____ Prescriber Signature/Dispense as Written (DAW)*	☒ _____ Prescriber Signature/Substitution Permitted (no stamps or initials)	_____ Date of Signature* (MM/DD/YYYY)