

NITYR® (nitisinone) Tablets Enrollment Form

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

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

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 Name (First, Last)*:		Date of Birth*:		Gender*: ☐ Male ☐ Female ☐ Other	
	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):		

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/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:

PRESCRIBER INFORMATION	Prescriber Name (First, Last)*:		Facility/Clinic Name*:		
	Prescriber Tax ID*:		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*:
	Office Contact Name (First, Last)*:		Office Contact Email*:		Office Contact Phone Number*:

CLINICAL INFORMATION	Primary Diagnosis*:		Diagnosis Code*: ☐ ICD-10: E70.21 (HT-1) ☐ 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 ☐ Please list the names of any medications the patient currently takes (if any):				

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Patient Name (Printed)*:	Date of Birth*:
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PRESCRIPTION	Ship to: ☐ Prescriber's Office ☐ Hospital Pharmacy ☐ Patient Residence ☐ First Fill ☐ Always		
	☐ Bridge Program[§] - "Bridge" is a FREE supply of NITYR that allows patients diagnosed with HT-1 to begin therapy immediately while Cycle Vita secures appropriate benefit verification and authorization. "Bridge" may also be requested for existing patients who are temporarily experiencing disruption in therapy due to insurance coverage.*		
	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 (e.g., Medicaid, Medicare, private insurance, etc.) for payment/reimbursement for any free product(s) provided by Cycle Vita. I agree and understand that any free product provided by Cycle Vita may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on this form. Cycle Vita reserves the right to modify or terminate the program 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.		
	Please select one*:		
	☐ 2mg NITYR® (nitisinone) Tablets (NDC: 70709-002-60)	☐ 5mg NITYR® (nitisinone) Tablets (NDC: 70709-005-60)	☐ 10mg NITYR® (nitisinone) Tablets (NDC: 70709-000-60)
	Number of days' supply/prescription: ☐ 30 days ☐ 90 days and _____ Refill(s)	Number of days' supply/prescription: ☐ 30 days ☐ 90 days and _____ Refill(s)	Number of days' supply/prescription: ☐ 30 days ☐ 90 days and _____ Refill(s)
	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. Only prescriptions filled with the product NDC numbers listed above will be eligible for Cycle Vita (Eligible Programs).*		

ADMINISTRATION INSTRUCTIONS		Patient CAN swallow tablet(s)	Patient CANNOT swallow tablets	
	Morning ____ 2mg tablet(s) and ____ 5mg tablet(s) and ____ 10mg tablet(s) and Afternoon ____ 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
	Special Instructions:			

PRESCRIBER DECLARATION	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.		
	X _____ Prescriber Signature* (no stamps or initials) Dispense as Written*	_____ (Substitution Permitted)	_____ Date of Signature* (MM/DD/YYYY)