

Patient Enrollment Form for VENXXIVA™ (tiopronin) Delayed-Release Tablets

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



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

All required fields are burgundy and noted with an asterisk*

PATIENT INFORMATION	Patient Last Name* _____		Patient First Name* _____	
	Date of Birth* _____	Gender* ☐ Male ☐ Female ☐ Other		
	Parent/Guardian Name (if patient is a minor) / Caregiver Name _____		Relationship to Patient _____	
			Power of Attorney / Medical Proxy ☐ Yes ☐ No	
	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): _____				

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* _____	

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 ☐ Patient requires Co-Pay only			
	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			

Patient Full Name*	Date of Birth*
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CLINICAL INFORMATION	Diagnosis ICD-10 code* ☐ E72.01 Cystinuria ☐ Other (please specify):
	Date of diagnosis: Primary diagnosis:
	Patient history with tiopronin* ☐ Has never been prescribed tiopronin ☐ Is currently prescribed generic tiopronin ☐ Is currently prescribed branded tiopronin Other (please specify):
	Patient Allergies* ☐ No Known ☐ Known (please list known allergies):
	Patient Medications* ☐ None ☐ Please list the names of any other health conditions the patient currently has (if any):
Weight: Lbs OR Kg	

PRESCRIPTION INFORMATION	☐ VENXXIVA (tiopronin) Delayed-Release Tablets* 100 mg	NDC Number: 70709-121-30
	☐ VENXXIVA (tiopronin) Delayed-Release Tablets* 300 mg	NDC Number: 70709-123-90
	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)*	
	Adults: The recommended initial dose in adult patients is 800 mg/day. Pediatrics: The recommended initial dose in pediatric patients 9 years of age and older is 15 mg/kg/day. Administer VENXXIVA (tiopronin) Delayed-Release Tablets in 3 divided doses at the same times each day, without food.	
	Patient Directions (check all that apply)* ☐ Take 100 mg VENXXIVA (tiopronin) Delayed-Release Tablets, daily, for a total dose of mg/day ☐ Take 300 mg VENXXIVA (tiopronin) Delayed-Release Tablets, daily, for a total dose of mg/day ☐ Please contact your physician before starting use of the medication ☐ Other (please specify)	
	☐ Bridge Program* - "Bridge" is a FREE supply of VENXXIVA (tiopronin) Delayed-Release Tablets that allows patients with a valid prescription 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.	
	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 VENXXIVA (tiopronin) Delayed-Release Tablet product(s). I agree and understand that any free VENXXIVA (tiopronin) Delayed-Release 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 VENXXIVA (tiopronin) Delayed-Release 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 VENXXIVA (tiopronin) Delayed-Release 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)*		
	X Prescriber Signature/Dispense as Written (DAW)* (no stamps or initials)	X Prescriber Signature/Substitution Permitted (no stamps or initials)	Date of Signature* (MM/DD/YYYY)