Orfadin4U® Enrollment Form

Phone: 877-473-3179 **Email: Orfadin.US@Sobi.com** **Fax Enrollment Form to: 877-473-3049**

Patient Information

(Last Name) (First Name) (Middle Initial)	(Parent/Guardian Last Name) (First Name) (Middle Initial)
(Primary Phone)	(Alternate Phone)
(Home Address)	(Email Address)
(City) (State)	(Zip)
Gender ☐ M ☐ F	(Date of Birth) (Age in Years)
Primary Language: ☐ English ☐ Spanish ☐ Other_____	

Patient Insurance Information (Attach and FAX copy of card, front and back)

Primary Medical Carrier:	Primary Insured	Prescription Benefit Carrier:	Primary Insured
ID#	Employer	ID#	Employer
Group #		Group #	PCN # / BIN#
Member Service Telephone #		Member Service Telephone #	

Patient Medical and Treatment History

(Primary Diagnosis/ICD-10) _____ (Secondary Diagnosis/ICD-10) _____	Liver Transplant: ☐ Yes (Date_____) ☐ No
(Weight)_____kg/lbs (circle one) Height:_____	Patient Allergies: / Date of First Orfadin Treatment:
Other Prescription Medications:	

Prescription

☐ **Orfadin® (nitisinone) 4 mg/ml. suspension**	**Directions for use:**_____	**#/Qty:**_____ **/ Refills:**_____
☐ **Orfadin® (nitisinone) 2 mg capsules**	**Directions for use:**_____	**#/Qty:**_____ **/ Refills:**_____
☐ **Orfadin® (nitisinone) 5 mg capsules**	**Directions for use:**_____	**#/Qty:**_____ **/ Refills:**_____
☐ **Orfadin® (nitisinone) 10 mg capsules**	**Directions for use:**_____	**#/Qty:**_____ **/ Refills:** _____
☐ **Orfadin® (nitisinone) 20 mg capsules**	**Directions for use:**_____	**#/Qty:**_____ **/ Refills:** _____

Prescriber Signature _____ _____ *Date* _____

Substitution *Permitted* *Dispense as Written*

NY Prescribers submit prescription on an original NY State prescription blank
TN Prescribers quantity must be written in both numerals and words

Prescriber Information

(Prescriber Name)	(NPI #)
(Practice/Hospital Affiliation)	
(Primary Phone)	(FAX)
(Address)	
(City) (State)	(Zip)
(Office Contact)	(Specialty)

Prescriber Consent (signature required)

By signing below, I certify that (a) the above therapy is medically necessary and that I will supervise the patient's treatment accordingly;
(b) I have received the necessary authorizations, including those required by state law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to release the above information and other health and medical information of the patient to SOBI, Inc., Dohmen Life Science Services, its agents and contracted dispensing pharmacies, to assist the patient in obtaining coverage for Orfadin. If the patient is 18 years old or younger, I attest that I have obtained permission from the patient's legal guardian.

Prescriber Name (Please Print Prescriber Signature (Required) Date