



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	<input type="checkbox"/> M <input type="checkbox"/> F	(Date of Birth)	(Age in Years)	Primary Language:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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-9) _____ ICD-10 _____	Liver Transplant: <input type="checkbox"/> Yes (Date _____) <input type="checkbox"/> No	
(Secondary Diagnosis/ICD-9) _____ ICD-10 _____	Date of Diagnosis:	Date of First Orfadin Treatment:
(Weight) _____ kg/lbs (circle one) Height: _____	Patient Allergies:	
Other Medical Conditions:		
Prior Orfadin Dose: _____	Date of Dose Change _____	
Other Prescription Medications: _____		

Prescription

Orfadin® (nitisinone) 2 mg capsules
 Orfadin® (nitisinone) 5 mg capsules
 Orfadin® (nitisinone) 10 mg capsules

#/Quantity: _____ / Refills: _____
 Quantity: _____ / Refills: _____
 Quantity: _____ / Refills: _____

Directions for use _____ Total Mgs to be taken at each dose: _____

Prescriber Signature _____
 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
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