



Sucraid® (sacrosidase) Oral Solution **Enrollment Form**
Phone: 866-740-2743 (CSID) Fax: 866-777-7097

Last Name		First Name		Today's Date		Date Needed	
Home Phone Number ()		Work Phone Number ()		Prescriber		Hospital/Clinic	
Home Address		City	State	Zip	Address		City State Zip
Shipping Address (if different from home address)			<input type="checkbox"/> Physician	<input type="checkbox"/> Home	<input type="checkbox"/> Other	Phone Number ()	
							Fax Number ()
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other				Office Contact		Physician Specialty	
Social Security Number			Date of Birth		Preference: <input type="checkbox"/> Fax <input type="checkbox"/> Phone <input type="checkbox"/> Email		
					Email		
Allergies			Patient Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg		Special Instructions		

INSURANCE INFORMATION (fill out entirely or fax a copy of patient's insurance card, both sides)
PRIMARY INSURANCE: _____
Name of Insured: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____
SECONDARY INSURANCE: _____
Name of Insured: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____
Statement of Medical Necessity
Primary Diagnosis: _____
ICD-9 Code: _____
Estimated Therapy Start Date: _____
Medical History: _____
PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS
_____ Physician Signature
_____ UPIN/DEA#
_____ State License#

PLEASE COMPLETE THE FOLLOWING:
<input type="checkbox"/> SUCRAID® (sacrosidase) Oral Solution 8500 I.U./ML (2 X 118 ML)
SIG: _____
QUANTITY: 30 day supply (default) Other _____ days supply
REFILLS X: _____ MONTHS
Authorization to Use and Disclose Protected Health Information ("Authorization"): I authorize my pharmacy, CuraScript, Inc., QOL Medical LLC, the maker of Sucraid, my physicians and other healthcare providers, pharmacists, insurers, and any agent or representative of any of these parties (collectively, "Authorized Parties") to obtain information regarding me or my medical condition, insurance coverage and payment history, and to collect, use and disclose my individually identifiable health information ("IIHI") among each other and to/from third parties (which may include insurers, public funding programs, social workers, advocacy organizations, assistance organizations, healthcare providers and other persons or entities as any of the Authorized Parties may deem appropriate) to: (1) coordinate my treatment; (2) facilitate reimbursement support and obtaining payment for my treatment; (3) provide me and my healthcare providers with free educational materials; (4) conduct healthcare marketing activities, including those for which CuraScript receives compensation; and (5) carry out any other purpose required or permitted by law. I understand that any of the Authorized Parties may need to contact me for additional information. For purposes of this authorization, I understand that my IIHI includes any individually identifiable information about me such as my social security number, contact information, medical condition or other health information, and treatment and payment history relating to my past, present and future use of Sucraid and other health care items or services. I understand that once my information is disclosed under this authorization it may be further disclosed and no longer protected by federal confidentiality laws. I understand that treatment by my physician and payment, enrollment or eligibility to receive Sucraid is not conditioned upon the signing of this authorization. However, if I refuse to sign this authorization, my ability to receive support services related to my use of Sucraid may be limited. I understand that this authorization will remain in effect until the later of ten (10) years from the date of my signature or five (5) years following my discontinuance of purchase of Sucraid from CuraScript unless I revoke it by sending written notice to the Sucraid Program Manager at CuraScript at 6272 Lee Vista Blvd, Orlando, FL 32822. If I revoke this authorization, CuraScript will communicate my revocation to the Authorized Parties and will stop using and disclosing my information as soon as possible. However, my revocation will not affect any prior use or disclosure of IIHI made in reliance on this authorization and my revocation will not affect my treatment by my physician. If I have questions about disclosures of my IIHI, I may contact the Privacy Officer at CuraScript, Inc at (314) 810-3019. I understand that I have the right to receive a copy of this authorization.
Patient name (please print): _____
Signature of patient (or personal representative): _____
Relationship to patient (if applicable): _____
Date: _____