

# Therapeutic Response Dose (TRD) Program Enrollment Form

## Sucraid® (sacrosidase) Oral Solution

Phone: 866-740-2743

Fax: 866-777-7097

### Patient Information

Last Name:		First Name:	
Home Phone #:		Work Phone #:	
Address:			
City:		State:	Zip:
DOB:		Ship To: Patient Physician	
Allergies:		Patient Weight: Lbs      Kg	
Language Preference:      English      Spanish      Other			

### Physician Information

Today's Date:		Date Needed:	
Prescriber Name:			
DEA #:		Specialty:	
Prescriber Address:		City:	
State:		Zip:	
Phone Number:		Fax Number:	
Email			

<b>Disaccharide Deficiency Testing Performed:</b>  Yes  No	<b>Primary Presenting Symptom:</b> Diarrhea      Bloating Gassiness      Failure to Thrive Abdominal Pain      Other	<b>Secondary Presenting Symptom:</b> Diarrhea      Bloating Gassiness      Failure to Thrive Abdominal Pain      Other
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Statement of Medical Necessity
<b>ICD-9 Code:</b> 271.3      Intestinal Disaccharidase Deficiencies & Disaccharide Malabsorption  Other
<b>Medical History:</b>   

Please Complete the Following
<b>Medication:</b> SUCRAID® (sacrosidase) Oral Solution 8500 IU/mL
<b>SIG:</b>
<b>QTY:      118mL</b>
<b>PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS</b>
<b>X</b> _____

*Therapeutic Response Dose is used as a one-time dispense per patient. Please refer to [www.sucraid.net](http://www.sucraid.net) for instructions on "How to Order".*

