Rx Sucraid®
(sacrosidase) Oral Solution

SucraidASSIST™

Phone: 1-800-705-1962
Fax: 1-800-632-1944
sucraid@onepatientservices.com

Patient assistance is available

## Patient Information

Patient Name _____ DOB ___/___/___ Today's Date ___/___/____

Parent/Guardian Name _____ Relationship to Patient _____

Home Address _____ City _____

State _____ Zip _____ Preferred Contact # _____ Alternate # _____

Preferred Language _____ Email _____

Shipping address (if different from above) _____

Best Time to Contact _____ Allergies _____

I authorize Sucraid*ASSIST*™ to leave a message, including the prescription name Sucraid® (sacrosidase) Oral Solution, if I am unavailable when they call. ☐ Yes ☐ No

Sucraid*ASSIST*™ is a personalized program for Sucraid® patients and their prescribers. This support program provides insurance benefit verification, insurance appeals assistance, copay assistance, financial assistance, peer support coaching, nutrition counseling and educational resources related to your disease. In addition, as part of the support program, we offer nurse call support services to provide information and respond to your questions regarding your disease and Sucraid®.

**I would like to participate in these services:** ☐ Yes ☐ No Patient/Parent Signature (required) _____

Please review and sign the HIPAA statement on page 2.

## Prescription and Prescriber Information

### ☐ Sucraid® Rx 8500 IU/mL Prescription

Take_____mLs by mouth with snacks and meals.

See package insert for full dispensing instructions (typically 1mL for pts < 15kg and 2mLs for pts >15kg)

**_____# of meals per day + _____# of snacks per day = _____total meals & snacks per day**

☐ 30-day supply ☐ 60-day supply ☐ 90-day supply (as allowed by insurance)

_____Refills

I authorize One Patient Services, LLC to act as an agent of prescriber on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy.

**Signature Required (no stamps allowed):**

**Dispense as written**_____**Date**_____**or**

**Substitution allowed**_____**Date**_____

**Prescriber must review and sign the Diagnosis section on page 2.**

Prescriber Name _____

Office Name _____

Office Contact _____

Telephone # _____

Fax # _____

NPI # _____

State License # _____

Address _____

_____

City _____

State _____ Zip _____

This prescription is valid only if sent by facsimile. The physician is to comply with their state specific prescription requirements such as, e-prescribing, state specific prescription form, fax language, etc. Non-compliance of state specific requirement could result in outreach to prescriber.

## Please fax a copy of the front and back of the patient's insurance card or complete the information below

**PRIMARY INSURANCE:**

Name of Insured_____

Policy #_____

Group #_____

Phone #_____

Rx Drug Card #_____

**SECONDARY INSURANCE:**

Name of Insured_____

Policy #_____

Group #_____

Phone #_____

Rx Drug Card #_____

## Patient Financial Information (Only required if financial assistance is needed)

Current Annual Household Income: $_____ Number of People in Household: 1 2 3 4 5 6 Other: _____

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## Diagnosis and Prescriber Authorization

**Diagnosis (Please include ICD-10 code):**_____ **Description:** _____

I certify that I have received the appropriate permission and written authorization from the patient to release the medical and/or patient information referenced on this form relating to the above referenced patient to One Patient Services, LLC, QOL Medical, LLC and its affiliated companies, agents and representatives, and contracted third parties for the purposes of seeking reimbursement support, verifying insurance coverage and/or the evaluation of the patient's eligibility for alternate sources of funding, contacting the patient for the purpose of enrollment in the Sucraid*ASSIST*™ support program, and to facilitate product fulfillment via the dispensing specialty pharmacy.

Prescriber Name (Please print) _____

Prescriber Signature (Required) _____

## Please have the patient or caregiver sign the HIPAA statement below

**Authorization to Use and Disclose Protected Health Information ("Authorization"):** I authorize my pharmacy, Accredo Health Group, Inc. (Accredo), QOL Medical, LLC, the maker of Sucraid®, One Patient Services, LLC, Sucraid® support service provider, dietary consultants, my physicians, and other healthcare providers, pharmacists, insurers, and any agent or representative of any of these parties (collectively, "Authorized Parties") to obtain individually identifiable health information ("IIHI") regarding me and my medical condition, symptoms, treatments, family medical history, insurance coverage and payment history, and diet, and to collect, use, and disclose my IIHI among each other to/from third parties (which may include insurers, public funding programs, social workers, advocacy organizations, assistance organizations, healthcare providers, dietary consultants, and other persons or entities as any of the Authorized Parties may deem appropriate) to: (1) coordinate my treatment; (2) facilitate reimbursement support and obtain payment for my treatment; (3) provide me and my healthcare providers with free educational materials, dietary support, and/or peer consultation (4) conduct healthcare marketing activities, including those for which Accredo or One Patient Services, LLC receives compensation (5) conduct clinical assessments regarding therapeutic response to Sucraid® and (6) 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 healthcare 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® unless I revoke it by sending written notice to the One Patient Services Manager at One Patient Services, 7003 Presidents Drive, Suite 800, Orlando, FL 32809. If I revoke this authorization, One Patient Services, LLC 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 One Patient Services at sucraid@onepatientservices.com. I understand that I have the right to receive a copy of this authorization. I further understand that I have the right at any time to refuse nursing support, dietary support or peer consultation.

Patient Name (please print)_____Date_____

Patient Signature (or representative)_____Relationship to Patient (if applicable)_____

One Patient Services
7003 Presidents Drive, Suite 800
Orlando, FL 32809

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