

This prescription is New Re-Order

Patient Information

Patient Name _____ DOB ___/___/___ Today's Date ___/___/___
 Parent/Guardian Name _____ Relationship to Patient _____
 Home Address _____ City _____
 State _____ Zip _____ Preferred Contact # _____ Alternate # _____
 Preferred Language _____ Gender M F
 Shipping Address (if different from above) _____
 Best Time to Contact _____ Allergies _____

 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)
 Number of 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 Name _____
 Practice Name _____
 Practice Contact _____
 Email _____
 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.

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 SucraidASSIST[™] support program, and to facilitate product fulfillment via the dispensing specialty pharmacy.

Prescriber Name (please print) _____

Prescriber Signature (required) _____

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 # _____

SucraidASSIST[™] Program

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

SucraidASSIST[™] 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) _____

Email _____

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 and to third party assistance persons or organizations 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, payment by my insurance, or enrollment in my health plan 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, including assistance in obtaining third party funding. I understand that this authorization will remain in effect until the later of ten (10) years from the date of my signature, five (5) years following my discontinuance of purchase of Sucraid[®], or as limited by state law 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 stop using and disclosing my information. 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) _____