Rx Sucraid®

(sacrosidase) Oral Solution

SucraidASSIST™
Phone: 1-800-705-1962
Fax: 1-866-850-9155
sucraid@onepatientservices.com

Patient assistance is available

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 _____

_____

Prescription and Prescriber Information

Sucraid® Rx 8500 IU/mL Prescription

Take_____mLs by mouth with snacks and meals for a 30-day supply.

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

Number of refills _____

Diagnosis (please include ICD-10 code):_____

Description: _____

I authorize US Bioservices to act on behalf of myself and my patient to initiate any de minimus authorization process from health plans including the submission of any necessary forms to such health plans.

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.

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 #_____