Sucraid® (sacrosidase) Oral Solution | Treatment Form

Need Help?
US Bioservices
Phone: 1-833-800-0122
Fax: 1-866-850-9155

INSTRUCTIONS: Please complete and fax this page to **1-866-850-9155**.

1 PATIENT INFORMATION

First Name:	Last Name:		DOB:
Address:	City:	State:	Zip:
Last 4 Digits of the SSN:	Legal US Resident: ☐ Yes ☐ No	Gender: ☐ Male	☐ Female
Preferred Phone:	Email:		
Ship Prescription to (optional): ☐ Caregiver ☐ HCP Office	Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening		

2 INSURANCE INFORMATION

☐ Patient does not have insurance	**Medical Insurance Name:**	**Pharmacy Insurance Name:**	
Phone:	Member ID #:	Phone:	Pharmacy ID:
Policyholder Name & DOB:		BIN:	PCN:

☐ **See secondary insurance information attached.** (**NOTE:** Be sure to include secondary insurance information when sending back these forms)

3 MEDICAL HISTORY (PLEASE INCLUDE ICD-10 CODE)

Diagnosis Code Category:	☐ Diagnosis (ICD-10):_____	☐ Other Diagnosis:	Allergies:

4 PRESCRIPTION FOR SUCRAID®

☐ Take 1 ml by mouth with every meal or snack. 8 times per day for 30-day supply (Pts <15Kg).
Dispense two bottles.
Number of refills_____

☐ Take 2 ml by mouth with every meal or snack. 6 times per day for 30-day supply (Pts >15Kg).
Dispense three bottles.
Number of refills_____

☐ Take _____ ml by mouth with every meal or snack. _____ times per day for _____ day supply.
Dispense _____ bottles.
Number of refills_____

I authorize US Bioservices to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

☐ **Dispense as written**

Prescriber Signature:

Date:

☐ **Substitution allowed**

Prescriber Signature:

Date:

Please attach a separate prescription if this section does not comply with your state's prescription law. Prescriptions from New York must be issued electronically.

5 PRESCRIBER INFORMATION

Prescriber Name:		Prescriber NPI #:	
Facility Name:		State License #:	
Address:	City:	State:	Zip:
Phone:	Contact Email:		
Office Contact Name:	Office Contact Phone:	Office Contact Fax:	

COLLABORATING PHYSICIAN SIGNATURE (IF APPLICABLE)

Prescriber Signature:	NPI:	Date:

6 PRESCRIBER CERTIFICATION

I certify that the information provided in this Sucraid® (sacrosidase) Oral Solution Treatment Form is complete and accurate to the best of my knowledge, I have prescribed Sucraid® based on my judgment of medical necessity, and I will supervise the patient's treatment. I certify that I have obtained my patient's written authorization in accordance with applicable state and federal law including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to agents and service providers of QOL Medical, LLC, One Patient Services, LLC, and Sucraid® dispensing pharmacies for benefits eligibility, coverage authorization and coordination and dispensing of Sucraid®. I authorize the forwarding of this prescription and information to a dispensing specialty pharmacy. I understand that neither I nor the patient may seek reimbursement for any free or discounted product received under any patient assistance program. If the patient has requested the shipment to my office, I agree not to receive any compensation for dispensing the product and I will clearly label and dispense only for use by the patient. I understand that I am under no obligation to prescribe Sucraid® or any QOL Medical, LLC drug and I have not received and will not receive any benefit from QOL Medical, LLC for prescribing a QOL Medical, LLC drug.

Prescriber Signature:	Date:

*(Original signature required - *If required by applicable law, please attach copies of all prescriptions on official state prescription forms)*