Sucraid® (sacrosidase) Oral Solution | Prescription Form

Need Help?
Optum Frontier Therapies
Phone: 1-833-800-0122
Fax: 1-866-850-9155

INSTRUCTIONS: Please complete and fax this page to **1-866-850-9155**. **E-prescribing:** Frontier Therapies II - Optum

1 PATIENT INFORMATION

First Name:	Address:
Last Name:	City:
Last 4 Digits of the SSN: DOB: / /	State: Zip:
Legal US Resident: ☐ Yes ☐ No Gender: ☐ Male ☐ Female	Preferred Phone:
Email:	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 up to 8 times per day for a 30-day supply (≤15 kg). Dispense two bottles. **Number of refills _____**	☐ Take 2 mL by mouth with every meal or snack up to 6 times per day for a 30-day supply (>15 kg). Dispense three bottles. **Number of refills _____**	☐ Take ____ mL by mouth with every meal or snack up to ____ times per day for a 30-day supply (>15 kg). Dispense ____ bottles. **Number of refills _____**	I authorize Optum Frontier Therapies 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**	☐ **Substitution allowed**
Prescriber Signature:	**Prescriber Signature:**
Date:	Date:

Please attach a separate prescription if this section does not comply with your state's prescription law. Certain states require e-prescribing, please check your state pharmacy laws.

5 PRESCRIBER INFORMATION

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

Collaborating Physician Name and NPI# Only in Applicable States

NOTE: Original signature required - If required by applicable law, please attach copies of all prescriptions on official state prescription forms.