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: Group#:

☐ **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-CM **Code E74.31**	☐ Other Diagnosis:	Allergies:

4 PRESCRIPTION FOR SUCRAID®

Sucraid® bottles
For children ≤15 kg, take 1 mL by mouth with every meal or snack up to 8 times per day.
Choose one:
☐ Dispense 2 bottles for a **30-day supply.**
☐ Dispense 6 bottles for a **90-day supply.**
Number of refills _____

Sucraid® single-use containers
For older children and adults >15 kg, take 2 mL by mouth with every meal or snack up to 6 times per day. **Choose one:**
☐ Dispense 180 single-use containers for a **30-day supply.**
☐ Dispense 540 single-use containers for a **90-day supply.**
Number of refills _____

☐ For older children and adults >15 kg, take 2 mL by mouth with every meal or snack up to _____ times per day.
Dispense _____(days*doses/day) single-use containers for a 30-day supply.
Number of refills _____

I authorize Optum Frontier Therapies to act as my authorized agent to the extent not prohibited to secure coverage from applicable health plans and to initiate the prior authorization process, including to sign any necessary forms on my behalf as my authorized agent and to submit required forms and patient data required to support a prior authorization request.

☐ **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. 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.