Patient Enrollment Form for Tiopronin Delayed-Release Tablets

Phone: +1 (888) 360-8482 FAX: +1 (888) 385-8482

To Enroll, fax this form: + 1 (888) 385-8482

Or email: hello@cyclevita.life

All required fields are purple and noted with an asterisk*

PATIENT INFORMATION

Patient Last Name*	Patient First Name*
Date of Birth*	Gender* ☐ Male ☐ Female ☐ Other
Parent/Guardian Name *(if patient is a minor) / Caregiver Name*	Relationship to Patient
Street Address*	Suite/Floor/Apt #
City*	State* Zip code*

Preferred Method of Contact (please specify)*
☐ Cell Phone ☐ Alternate Phone
☐ Email

Language Preferred* ☐ English ☐ Spanish ☐ Other (please specify):

Weight Lbs OR Kg

PRESCRIBER INFORMATION

Prescriber Last Name*	Prescriber First Name*	
Prescriber Office/Site/Clinic*		
Prescriber Phone Number*	Prescriber Fax Number*	
Street Address*		
City*	State*	Zip Code*
NPI Number*		
Office Contact Name*		
Office Contact Phone Number with Extension*	Office Email Address*	
DEA	Medicaid UPIN	State License

INSURANCE INFORMATION

Please attach a copy of the prescription insurance benefit card, front and back, or complete the following*
☐ Prescription insurance benefit card attached ☐ Patient does not have insurance ☐ Patient requires Co-Pay only

Primary Insurance Company Name*		Secondary Insurance Company Name	
Primary Insurance Company Phone Number*		Secondary Insurance Company Phone Number	
Name of Primary Cardholder*		Name of Primary Cardholder	
Primary Insurance Member ID*	Group ID*	Secondary Insurance Member ID	Group ID
BIN*	PCN*	BIN	PCN

Prior Authorization Status*
☐ Submitted ☐ Not submitted ☐ Approved ☐ Denied

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Patient Full Name*	Date of Birth*

CLINICAL INFORMATION

Diagnosis ICD-10 code*: ☐ E72.01 Cystinuria ☐ Other (please specify): ____________________

Date of diagnosis: ____________________ Primary diagnosis: ____________________

Patient history with tiopronin:*

☐ Has never been prescribed tiopronin ☐ Is currently prescribed tiopronin ☐ Other (please specify): ____________________

Patient Allergies* ☐ No Known ☐ Known (please list known allergies): ____________________

Patient Medications*: ☐ None ☐ Please list the names of any other health conditions the patient currently has (if any): ____________________

PRESCRIPTION INFORMATION

Product	NDC Number
☐ Tiopronin Delayed-Release 100 mg Tablets*	NDC Number: 13668-691-03
☐ Tiopronin Delayed-Release 300 mg Tablets*	NDC Number: 13668-692-90

Only prescriptions filled with the product NDC number listed above will be eligible for Cycle Vita (Eligible Programs).

Number of days' supply/prescription*: ☐ 30 days ☐ 90 days

Refill(s)*: ____________________

Adults: The recommended initial dose in adult patients is 800 mg/day.

Pediatrics: The recommended initial dose in pediatric patients 9 years of age and older is 15 mg/kg/day.

Administer Tiopronin Delayed-Release Tablets in 3 divided doses at the same times each day, without food.

Patient Directions (check all that apply)*

☐ Take ______ 100 mg Tiopronin Delayed-Release Tablets, _______ daily, for a total dose of ______ mg/day.

☐ Take ______ 300 mg Tiopronin Delayed-Release Tablets, _______ daily, for a total dose of ______ mg/day.

☐ Please contact your physician before starting use of the medication.

☐ Other (please specify): ____________________

☐ Bridge Program[†] - "Bridge" is a FREE supply of Tiopronin Delayed-Release Tablets that allows patients with a valid prescription to begin therapy immediately while appropriate benefit verification and authorization is identified. "Bridge" may also be requested for existing patients who are temporarily experiencing disruption in therapy due to insurance coverage.

By checking the box above for Bridge, I, as the prescriber, with my signature below on this form, agree and attest that I will not submit a claim to or seek payment from the patient or any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment/reimbursement for any free Tiopronin Delayed-Release Tablet product(s). I agree and understand that any free Tiopronin Delayed-Release Tablet product(s) provided may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on this form. The Bridge program may be modified or terminated without notice at any time.

[†]Bridge is at no cost, for eligible patients within labeled indication only, and not contingent on purchase of any kind. Bridge is intended to support continuation of prescribed therapy if there is any disruption in therapy due to insurance coverage.

PRESCRIBER DECLARATION

Prescriber Declaration: I understand and agree that, as the prescriber, I will comply with my state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to me, as the prescriber. I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed Tiopronin Delayed-Release Tablets based on my professional judgment of medical necessity. I authorize Cycle Vita, its affiliates, agents, and contractors (collectively, "Cycle Vita" to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the above-named patient utilizing their benefit plan. I authorize Cycle Vita, its affiliates, agents and contractors to perform any steps necessary to secure reimbursement for Tiopronin Delayed-Release Tablets, including but not limited to insurance verification and case assessment. I understand that Cycle Vita may need additional information, and I agree to provide it as needed for the purposes of securing reimbursement.

Prescriber Signature (please select one of the options below)*

X ____________________	X ____________________	____________________
Prescriber Signature/Dispense as Written (DAW) (no stamps or initials)	Prescriber Signature/Substitution Permitted (no stamps or initials)	Date of Signature (MM/DD/YYYY)

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