PYROS™
TOTAL CARE

Prescription and Enrollment Form for VIGAFYDE™ or VIGPODER™

Instructions: FILL OUT and FAX completed form and attachments to 1-855-813-2039.
Call 1-888-760-8330 if you have any questions regarding this form or to contact Pyros Total Care.

1. PATIENT

Please select one: ☐ Newly prescribed Patient ☐ Patient currently on vigabatrin

Last Name | First Name | Preferred Language | ☐ M ☐ F Gender

Home Address | City | State | Zip

DOB | Weight (kg) | Height | Date of Measurement

Parent/Guardian | Relation to Patient

☐ Home ( ) – ☐ Work ( ) – ☐ Mobile ( ) –

Parent/Guardian Phone (Please check preferred)

Emergency Contact | Phone ( ) – | Okay to leave voicemail ☐ YES ☐ NO

2. INSURANCE *(PLEASE ATTACH COPIES OF FRONT AND BACK OF ALL MEDICAL AND PRESCRIPTION INSURANCE CARDS AS PART OF YOUR FAX)*

Medical Plan Name	Prescription Card Name	Secondary Insurance Plan Name
Member #	Phone #	Member #
Group #	Member #	Group #
Policy holder name	Group #	Policy holder name
Relationship to policy holder		Relationship to policy holder

3. PRESCRIBER

Prescriber Name/Title | NPI | State License #

Facility Name | Address | City | State | Zip

Office Contact Name | Phone # | Fax #

Contact's Email | Preferred Contact Method: ☐ Phone ☐ Email ☐ Fax

4. PRESCRIPTION *(CHOOSE ONE)*

VIGAFYDE™ (vigabatrin) Oral Solution

NDC 80789-003-15

Vigafyde *(100 mg/mL oral solution)*

SIG: Use oral syringe provided to measure correct volume for dose.

Administer _____ mLs by mouth twice daily.

Instruction

Dispense: ☐ 30 Days Supply **Quantity (mL):** **Refill Quantity:**

OR

VIGPODER™ (vigabatrin) for Oral Solution, USP

NDC 80789-117-50

Vigpoder *(500 mg powder, for oral solution)*

SIG: Mix each packet with 10 mLs of water to achieve the correct volume.

( ) packets needed per dose). **Discard any unused portion.**

Administer _____ mLs (mg) by mouth twice daily.

Instruction

Dispense: ☐ 30 Days Supply **Quantity of Packets:** **Refill Quantity:**

5. DIAGNOSIS *(PLEASE INCLUDE COPIES OF CLINICAL NOTES)*

Please provide all appropriate ICD-10 codes:

Allergies:

I hereby certify that I am prescribing the above medication for the named patient, and I affirm that the therapy described above is medically necessary based on my professional judgment.

Dispense Written (Live Signature Required—Stamped Signatures Are Not Valid)	**Substitution Allowed** (Live Signature Required—Stamped Signatures Are Not Valid)	**Date Written**

6. PATIENT AUTHORIZATION

Please attach separate Patient Authorization as part of your fax. If the parent/guardian is not present to sign the Patient Authorization, direct them to *PTCConsent.com* to sign electronically.