Nitisinone Capsules

If you have questions, please call 844-397-0541

Please fax form to 855-813-2039

eTon CARES

PATIENT REFERRAL FORM

Patient Information **Please print*

Last Name: First Name:		SSN:	Sex: M F
Address:	City:	State:	Zip:
Phone: Day #	Evening #:	Cell # :	Preferred method of Contact: Day # Evening # Cell #
DOB:	Weight Lbs:	Kg:	Height:
If Patient is a Minor, Guardian/Parent Name:		Relation to Patient:	
Emergency Contact:		Phone #:	

Insurance Information

Primary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:
Prescription Card Name:		Phone #:
Policy #:		Group #:
Secondary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:

Physician Information

Prescriber Name/Title:			
NPI: DEA:		Medicaid UPIN:	State License #:
Address:	City:	State:	Zip:
Practice Name:			
Name of Contact Person:			Phone:
Physician Email:			Fax:

Prescription

Nitisinone Capsules:

Refills _____

The recommended starting dosage is 0.5mg/kg twice daily

Nitisinone 2mg Capsules Dosage Instructions: _____ AM ; _____ PM Qty: _____

Nitisinone 5mg Capsules Dosage Instructions: _____ AM ; _____ PM Qty: _____

Nitisinone 10mg Capsules Dosage Instructions: _____ AM ; _____ PM Qty: _____

Nitisinone 20mg Capsules Dosage Instructions: _____ AM ; _____ PM Qty: _____

Special Instructions:

_____

_____

_____

Medical Necessity

Please check applicable ICD-10 code:

☐ Tyrosinemia (E70.21) ☐ Other _____

☐ NKDA Allergies: _____

I certify I am prescribing Nitisinone for this patient for a medically necessary purpose.

Date Written: _____

Dispense as Written: _____
(Stamped Signatures Are Not Valid)

Substitution Allowed:
(Stamped Signatures Are Not Valid)_____

This Prescription Form is only valid if FAXED to Anovo @855-813-2039

Form: NitisinoneRx.01
Effective Date: 10/1/2025
1518-v1