

Betaine anhydrous Enrollment Form

Fax Referral To: 1-800-323-2445

Phone: 1-800-237-2767

Email Referral To: Customer.ServiceFax@CVSHealth.com

DATIENT INFORM	Six Simple Steps to Si ATION (Complete or include demograp		
	A HON (Complete of include demograp		Gender: Male Female
Address:	City, Sta		Gender. Male Tentale
Preferred Contact Methods: Note: Carrier charges may app	Phone (to primary # provided below) Text (to bly. If unable to contact via text or email, Specialty F	o cell # provided below)	act by phone.
Email:	Last Four	of SSN: Prir	nary Language:
	/Guardian Name (Last, First):		
Relationship to minor:			
PRESCRIBER INFO	DRMATION		
Prescriber's Name:	#:Group or Hospital:	State License #:	
NPI #: DEA #	f: Group or Hospital:	Chata ZID Carles	
Address: Phone:	CityFax:Contact Per	y, State, ZIP Code:	Contact's Phone:
⊴ INSURANCE INFO	RMATION Please fax copy of prescription	on and insurance cards wit	h this form, if available (front and back)
	CLINICAL INFORMATION		
Needs by Date:	Ship to: Patient	U Office U Other:	
Diagnosis (ICD-10): ☐ E72.11 Homocystinuria ☐ E72.12 MTHFR Deficiend			nalonic Acidemia with Homocystinuria
Therapy Start date:			
Patient Clinical Informa	ition:		
<u>A</u> llergies:	NKDA	Weight:	🗌 lb 🗌 kg Height: 🗌 in 🗌 cm
5 PRESCRIPTION IN	IFORMATION		
MEDICATION	DOSE & DIR	ECTIONS	QUANTITY/REFILLS
Betaine anhydrous for oral solution powder 1 bottle = 180 grams	Dissolve scoop(s) in 4–6 ounces (1) formula, or mixed with food for immediate (Note: 1 scoop = 1 gram) Solution should be taken time(s) daily.	ingestion.	, milk, or Quantity: bottles Refills:
	drous is only supplied in bottles containing 180 gran 's daily dose. Betaine anhydrous is not available in		
_	RESCRIBER SIGNATURE REQUIRED	_	
"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute		May Substitute / Product Selectic Substitution Permissible	
Prescriber's Signature:	Date:	Prescriber's Signature: _	Date:
CA, MA, NC & PR: Interchange is ma	andated unless Prescriber writes the words "No Substitution"	ATTN: New York and	I lowa providers, please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty® Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

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Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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