



**Patient Enrollment Form for KUVAN® (sapropterin dihydrochloride)
Tablets or Powder for Oral Solution**

Fax completed form with prescriber's signature to **1.888.863.3361**
 Phone: **1.877.MY.KUVAN** (1.877.695.8826); Hours: M–F, 6AM–5PM (PT)
 Email: **support@biomarin-rareconnections.com**



All required fields are purple and are noted with an asterisk*

PATIENT	Patient Last Name*		Patient First Name*		
	Date of Birth*		Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other		
	Street Address*			Parent/Guardian Name (if applicable)	
	City*			State*	ZIP Code*
	Preferred Method of Contact (please specify)*				
	<input type="checkbox"/> Cell Phone <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone				
	<input type="checkbox"/> Email				
	Language Preferred: <input type="checkbox"/> English <input type="checkbox"/> Other Language (please specify)				
Alternate Contact Name				Relationship to Patient	
Phone			Email		

INSURANCE	Please attach copies of the insurance and prescription benefit cards, front and back, or complete the following* <input type="checkbox"/> Patient has no insurance.			
	Primary Insurance Name*		Secondary Insurance Name	
	Insurance Phone Number*		Insurance Phone Number	
	Subscriber*		Subscriber	
	Relationship to Patient*		Relationship to Patient	
	Member ID*	Group ID	Member ID	Group ID
	Employer*		Employer	

DIAGNOSIS/CLINICAL	Diagnosis ICD-10-CM*		Baseline Blood Phe Levels (before trial)	
	<input type="checkbox"/> Classical Phenylketonuria (PKU) E70.0 <input type="checkbox"/> Other Hyperphenylalaninemias E70.1 (please specify)			
	<input type="checkbox"/> Phenylketonuria <input type="checkbox"/> Tetrahydrobiopterin Deficiency (BH4) <input type="checkbox"/> Hyperphenylalaninemia <input type="checkbox"/> Maternal Phenylketonuria			
	<input type="checkbox"/> Other Diagnosis (please specify) _____			
	Prolonged elevated blood phenylalanine (Phe) in adults can result in neurocognitive and neuropsychiatric impairment. I am prescribing KUVAN for this patient, and find it medically necessary to reduce blood Phe levels for this patient. I am prescribing KUVAN for this patient, and find it medically necessary for the following reasons (check all that apply):		Date	
<input type="checkbox"/> I want to reduce blood Phe levels in this patient. <input type="checkbox"/> Other _____				
Additional Comments				
Patient Allergies? <input type="checkbox"/> Unknown <input type="checkbox"/> Known If known allergies, please list _____				
Please list the names of other medications the patient is currently taking				
<input type="checkbox"/> None				

Patient Full Name*	Date of Birth*
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PRESCRIBER	Prescriber Last Name*	Prescriber First Name*	Prescriber Specialty: <input type="checkbox"/> Genetics <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Other (please specify)		
	Office/Site/Clinic*		Office Contact	Office Contact Phone Number	
	Phone Number*	Fax Number*	Email		
	Street Address*				
	City*		State*	ZIP Code*	
	State License Number		Medicaid Number		
	Tax ID		NPI Number*		

PRESCRIPTION	BioMarin will provide a 30-day supply of KUVAN® (sapropterin dihydrochloride) as a free trial for patients new to therapy			
	<input type="checkbox"/> Yes, provide patient with a free supply of KUVAN.			
	By checking this box, 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 product(s) provided by BioMarin. I agree and understand that any free product provided by BioMarin may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on this form.			
	Current weight _____ kg Dose per kg body weight: <input type="checkbox"/> 10 mg/kg <input type="checkbox"/> 20 mg/kg <input type="checkbox"/> Other _____ mg/kg			
	Number of days' supply/prescription: <input type="checkbox"/> 90 days <input type="checkbox"/> 30 days Number of refills: One (1) year			
	<input type="checkbox"/> KUVAN, Powder 500 mg / Number of packets per day			NDC Number: 68135-482-10
<input type="checkbox"/> KUVAN, Powder 100 mg / Number of packets per day			NDC Number: 68135-301-11	
<input type="checkbox"/> KUVAN, Tablet 100 mg / Number of 100 mg tablets per day			NDC Number: 68135-300-02	
Patient Directions (<i>check all that apply</i>): <input type="checkbox"/> Please contact your physician before starting use of this medication.			Shipping Instructions (<i>check if applicable</i>) <input type="checkbox"/> Dispensing pharmacy to notify prescriber when initial shipment is scheduled.	
<input type="checkbox"/> Take _____ 500 mg KUVAN (powder) and _____ 100 mg KUVAN (powder) once daily, as directed, with meal, for a total dose of _____ mg/day.				
<input type="checkbox"/> Take _____ 100 mg KUVAN (tablet) once daily as directed, with meal, for a total dose of _____ mg/day.				
<input type="checkbox"/> Other _____				
Bridge Prescription[†]				
<input type="checkbox"/> Check the box for Sonexus Health Pharmacy to dispense a bridge fill for KUVAN prescriptions if needed.				
†Bridge prescription is at no cost, for eligible patients within labeled indication only, and not contingent on purchase of any kind. Bridge prescription is intended to support continuation of prescribed therapy if there is a delay in insurance coverage determination. By checking the box above for bridge prescription, 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 product(s) provided by BioMarin. I agree and understand that any free product provided by BioMarin may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on this form. BioMarin reserves the right to modify or terminate the program without notice at any time.				

SPECIAL INSTRUCTIONS	
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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 KUVAN based on my professional judgment of medical necessity. I authorize BioMarin Pharmaceutical Inc., its affiliates, agents, and contractors (collectively, "BioMarin") 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 also authorize the BioMarin RareConnections™ program to perform any steps necessary to secure reimbursement for KUVAN, including but not limited to insurance verification and case assessment. I understand that BioMarin or BioMarin RareConnections may need additional information, and I agree to provide it as needed for the purposes of securing reimbursement.	
	Prescriber Signature. Please make a selection*	
	Prescriber Signature/Dispense As Written (no stamps or initials) Date	Prescriber Signature/Substitution Permitted (no stamps or initials) Date