



Date Written:

Dispense as Written: _

(Stamped Signatures Are Not Valid)

PATIENT REFERRAL FORM

Patient Information *Please print	Last Name: First Name:			SSN:				Sex:	M	O F
	Address:		City:	City: St		State:		Zip:		
	Phone: Day #	Evening #:			Cell # :		Preferred me Day #	thod of Conta Evening		Cell #
	DOB:	Weight Lbs:			g:	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 #:	roup #:			
	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:				N:		State Licer	nse #:		
	Address: City: Sta					ite:	Zip:			
	Practice Name:									
	Name of Contact Person:						Phone:			
	Physician Email:						Fax:			
Prescription	Nitisinone Capsules:						Refills			
	The recommended starting decage is 0 5mg/kg twice doily									
	Nitisinone 2mg Capsules Dosage Instructions: AM ; PM Qty:					ial Instruct	tions:			
	Nitisinone 5mg Capsules Dosage Ii				Qty:					
	Nitisinone 10mg Capsules Dosage Ii				Qty:					
	Nitisinone 20mg Capsules Dosage In				Qty:					
Medical Necessity	Please check applicable ICD-10 code:									
	Tyrosinemia (E70.21) Other									
	NKDA	Allergies:								
Loontif	I am neoccribing Niticipano forthis	ationt for a modical	llynococcomy m	irnoc	0					
I certifyI am prescribing Nitisinone for this patient for a medically necessary purpose.										

Form: NitisinoneRx.01 Effective date: 10/1/25 1518-v5

Substitution Allowed:

(Stamped Signatures Are Not Valid)__