

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

BET26-01

PATIENT INFORMATION				
First Name	Last Name	Date of Birth ____ / ____ / ____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		City	State	Zip
email		Home Phone	Cell Phone	

PRESCRIBER INFORMATION				
Prescriber Full Name			Prescriber Credential	
Office Address		City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone	
Practice Contact Person		Prescriber NPI	Preferred Contact Method <input type="checkbox"/> email <input type="checkbox"/> Phone <input type="checkbox"/> Fax	

CLINICAL INFORMATION – please include any relevant office visit/lab notes to support this prescription	
Patient is <input type="checkbox"/> Naïve <input type="checkbox"/> Previously Treated	Patient weight: ____ kg
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)	
Therapies Tried (please check name and include dates)	
<input type="checkbox"/> Vitamin B6 (Pyridoxine)	Date ____ / ____ / ____
<input type="checkbox"/> Vitamin B9 (Folic Acid)	Date ____ / ____ / ____
<input type="checkbox"/> Vitamin B12 (Cyanocobalamin)	Date ____ / ____ / ____
<input type="checkbox"/> Methionine Restricted diet	Date ____ / ____ / ____
<input type="checkbox"/> Other:	Date ____ / ____ / ____
Current Medications (please list name and dose):	
ICD-10 Code <input type="checkbox"/> E72.11 Homocystinuria	
<input type="checkbox"/> E72.12 5,10-methylenetetrahydrofolate reductase (MTHFR) deficiency	
<input type="checkbox"/> E71.12 Methylmalonic anemia (Cobalamin cofactor metabolism (sb1) defect)	
<input type="checkbox"/> Other:	

PRESCRIPTION – please check all boxes across row				
Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> <b>Betaine Anhydrous</b>	Oral Solution	<i>Pediatric Patient &lt; 3 years of age</i> <input type="checkbox"/> Start dose at 100 mg/kg (dissolved in 4-6 oz water, juice, milk or formula) divided into twice daily dosing. May increase dose weekly by 50 mg/kg increments. <input type="checkbox"/> Other:	<input type="checkbox"/> 1 bottle = 180 gm <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____
		<i>Adult and Pediatric Patients &gt; 3 years of age</i> <input type="checkbox"/> Take 3 gm (dissolved in water, juice or milk) by mouth twice daily <input type="checkbox"/> Other:		

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

**Prescriber's signature:** \_\_\_\_\_  MD  DO  PA  CRNP **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

**Note:** The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.