Bylvay (odevixibat) 200|400|600|1200 mcg capsules

Albireo Assist™ Enrollment Form

Call 855-ALBIREO with questions about properly completing this form.

A. Prescriber information

First name Stephen	Last name walker	Specialty healthcare		
Address 18 West Cortez Road, Bradenton, Florida, United States, 34201.		Phone 9514872487	Ext. 002	Fax 2345676
City Bradenton	State florida	Zip 34201	Office/Clinic/Institution name Apollo	
State license # 003003b0PI		Prescriber tax ID (Optional) 00Hu000		NPI # 003H03b0a
Primary contact name Iniyan		Phone 9514872487	Email surya.tvm.apm@gmail.com	

Preferred specialty pharmacy (selection will be honored if permitted by patient's insurance) ❍ Accredo ◉ Frontier Therapies – Optum ❍ PantherRx

B. Patient information

Preferred language English

First name Carls	Middle initial M	Last name Holland	Date of Birth 09 / 08 / 2003	◉ Male ❍ Female
Home phone (901) 989 9898	Work Phone (901) 979 6853	Email suryakumar543900@gmail.com	Address Maple St., Nome, Alaska, USA, 54021	

Parent/guardian first and last name (if applicable) Tom Holland	Relationship father	Email tomholland@gmail.com	Cell 9548762132
		Preferred contact ◉ Email ❍ Phone ❍ OK to leave message	
Parent/guardian 2 first and last name (if applicable) Jennifer	Relationship mother	Email jennifer@gmail.com	Cell 9456873151
		Preferred contact ◉ Email ❍ Phone ❍ OK to leave message	

Prescription drug information *Attach copies of both sides of the patient's pharmacy benefit card*

◉ Check if no coverage (If no coverage is determined, the patient will be considered for the Patient Assistance Program)

Prescription insurance information *Attach copies of both sides of the patient's insurance card(s)*

Primary insurance name Health Care poliyc		Policy holder name Jack M Williams		Date of Birth 09 / 08 / 2003
Insurance company phone 9578423174	Policy # 0030anPIAQ	Group # u0030anPIAQ		Last 4 digits of patient SSN 9876
Secondary insurance name value care policy		Policy # 003Hu0panPIAQ		Group # 003h0anPIAQ
Pharmacy Benefit Manager Tamil	RxBIN 555p	RxPCN BB55	RxGroup 9999	RxID 7u7u

C. Prescription for Bylvay™ (odevixibat) *See Dosing Tables to determine dosage by patient weight in kg*

Medication	Strength-Check box of requested dose	Directions†	Quantity	Days Supply	Refills
Bylvay™	◉ 200mcg oral pellets for sprinkle only*	◉ Sprinkle/mix with/over food 200 mcg total once daily	8	1	1
	◎ 600mcg oral pellets for sprinkle only*	❍ Take 30 mcg total swallowed whole once daily			
	◎ 400mcg capsule**				
	◎ 1200mcg capsule**				

*200mcg and 600mcg strengths must be opened and sprinkled, NOT swallowed whole
**400mcg and 1200mcg strengths can be opened and sprinkled OR swallowed whole

†Daily Dose must be a multiple of the listed strengths

Current weight: 70 **kg** (Date measured: 02 / 01 / 2015)

Prior Authorization # if known: _____ Prior Authorization Effective Dates: _____

Additional Considerations: not required Drug/Food Allergies: no ❍ No Known Drug Allergies

Concurrent Medications: ◉ Ursodeoxycholic Acid ❍ Rifampicin ❍ Other

Prescriber authorization

I authorize Albireo Pharmaceuticals, Inc. and its agents as my designated agent and on behalf of my patient to (1) forward this statement of medical necessity to furnish any information on this form to and recruit necessary patient information from the insurer of above-named patient and (2) forward this prescription, by any means under applicable law, fax or other mode of delivery, to the pharmacy. I certify that the rationale for prescribing Bylvay™ is for a primary diagnosis of PFIC and I will be supervising the patient's treatment accordingly. **CA, MA, NC & PR:** Interchange is mandated unless Prescriber writes the words "No Substitution." **ATTN: NY** and **IA** providers, please submit electronic prescription **Please select 1 option and sign only once below.**

▶ prashanth

PRESCRIBER'S SIGNATURE (dispense as written). Signature stamps not acceptable.

▶ prashanth

PRESCRIBER'S SIGNATURE (substitution permitted). Signature stamps not acceptable.

20 / 02 / 2014

DATE

Albireo makes no representation that the information will comply with the requirements of any particular payer/insurer. The use of this information does not guarantee payment or that any payment received will cover your costs. Special note: The physician is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

Clinical information *(Please include the patient's most recent chart notes)*

Primary diagnosis: progressive familial intrahepatic cholestasis (PFIC) ICD-10: hhfhfgfg4567

1. When was the patient first diagnosed with PFIC (month/year) 03 / 2016

2. Has the patient had genetic testing? ◉ Yes ◎ No

3. Severity of pruritus ◉ Mild ◎ Moderate ◎ Severe

AlbireoAssist™ Personalized Support Services HELPING NAVIGATE THE WAY

By fax: 866-853-0479