Bylvay (odevixibat)

Albireo Assist™ Enrollment Form

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

A. Prescriber information

First name JOHN	Last name WILLIAMS	Specialty	
Address		Phone	Ext. / Fax
City	State / Zip	Office/Clinic/Institution name	
State license #	Prescriber tax ID (Optional)	NPI #	
Primary contact name	Phone	Email	

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

B. Patient information

Preferred language

First name WALTER	Middle initial	Last name WHITE	Date of Birth 09/09/2001	◉ Male ❍ Female
Home phone 9573558248	Work Phone 9573558248	Email walter@gmail.com	Address Maple Street, Nome, Alaska, USA	

Parent/guardian first and last name (if applicable)	Relationship	Email / Preferred contact ❍ Email ❍ Phone ❍ OK to leave message	Cell
Parent/guardian 2 first and last name (if applicable)	Relationship	Email / Preferred contact ❍ Email ❍ Phone ❍ OK to leave message	Cell

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		Policy holder name	Date of Birth / /	
Insurance company phone	Policy #	Group #	Last 4 digits of patient SSN	
Secondary insurance name		Policy #	Group #	
Pharmacy Benefit Manager	RxBIN	RxPCN	RxGroup	RxID

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 _____ mcg total once daily			
	❍ 600mcg oral pellets for sprinkle only*	❍ Take _____ 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: _____ **kg** (Date measured: ____/____/_____)

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

Additional Considerations: _____ Drug/Food Allergies: _____ ❍ 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.**

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

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

____/____/_____
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:

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

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