DIACOMIT® Patient Access Enrollment Form

(to be completed by prescribers)

For more information, please contact US Bioservices at:
Phone: 833-248-0467 | Fax: 833-871-4137

DIACOMIT®
(stiripentol) 250 mg, 500 mg
capsules or powder for oral suspension

Complete the form below to help your patients get started on treatment.
An appropriate prescription must be submitted together with this enrollment form.

PATIENT CONTACT INFORMATION

Patient First Name

Patient Last Name

Address

City State Zip

Sex ☐ Male ☐ Female DOB / /

Home Phone Mobile

Email

Preferred Language

Best Time to Reach Me ☐ Morning ☐ Afternoon ☐ Evening

Ok to Leave Message via: Live Person ☐ Yes ☐ No; Voicemail ☐ Yes ☐ No

Authorized Representative

Relationship to Patient

Phone Number and Email for Authorized Representative (if different from above)

PATIENT INSURANCE INFORMATION

☐ Patient does not have insurance

Prescription Drug Insurer

ID # BIN #

PCN # Group #

Phone

Primary Medical Insurance

Cardholder's Name

Relationship to Cardholder ☐ Child ☐ Other

ID # Group # Phone

Secondary Medical Insurance

Cardholder's Name

Relationship to Cardholder ☐ Child ☐ Other

ID # Group # Phone

PRESCRIBER INFORMATION (TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY)

Prescriber First and Last Name

Prescriber Specialty

Practice Name

Address

City State Zip

License #

Prescriber DEA # Prescriber NPI #

Prescriber Phone Prescriber Fax

Prescriber Email

Office Contact Name Phone

Email

CLINICAL INFORMATION (TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY)

Diagnosis ICD-10

☐ Dravet syndrome G40.83
- Polymorphic epilepsy in infancy (PMEI)
- Severe myclonic epilepsy in infancy (SMEI)

☐ Dravet syndrome, intractable, with status epilepticus G40.833

☐ Dravet syndrome, intractable, without status epilepticus G40.834

☐ Other Diagnosis (please specify) _____

Is the patient currently taking clobazam? ☐ Yes ☐ No

Is the patient currently taking any other medications to treat Dravet syndrome?

☐ Yes ☐ No If yes, provide details

Medications Tried and Discontinued

Patient's Current Weight _____ kgs

WBC and Platelet Count (Provide Date)

Known Allergies

PRESCRIPTION INSTRUCTIONS

In order to prevent delay in starting your patient on DIACOMIT®, please submit a prescription with this enrollment form as well as any additional clinical information that supports insurance authorization.

If there is a delay in insurance authorization, Biocodex has designed a Quick Start program, subject to patient eligibility criteria. If you would like your patient to participate in this program, please submit a separate prescription for a 30-day supply with one refill to support providing DIACOMIT® to your patient while insurance authorization is pending. If you have questions about the program, please call US Bioservices at 833-248-0467.

PRESCRIBER AUTHORIZATION

I certify that this medication is medically necessary for the treatment of Dravet syndrome and that I am aware of the risks and benefits associated with the use of DIACOMIT®. By signing, I hereby authorize the release of medical and/or patient information to US Bioservices Corporation ("US Bioservices"), its affiliates, representatives, agents, assigns, and contractors (collectively, its "Representatives") to help enable treatment for this patient. I further certify that the patient is aware of, has consented to, and has directed my disclosure of their information to US Bioservices and its Representatives so that they may contact the patient to further enable services for prior authorization processing and fulfillment of the prescription. I authorize US Bioservices and its Representatives to act on behalf of myself and my patient to initiate any de minimus authorization process from health plans including the submission of any necessary forms to such health plans. Prescribers in New York must submit prescriptions via electronic submissions.

Prescriber Signature: _____ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. **Date** _____ / _____ / _____

PATIENT HIPAA AUTHORIZATION

This notice describes how medical information about you may be used and disclosed. Please review this notice carefully.

Patient's Name (Last, First) _____ **DOB** _____ /_____ / _____

I have read and agree to the following HIPAA Authorization to Share Health Information. I authorize my healthcare providers and health plans to disclose my personal, medical, financial, insurance, or third-party payer information, if applicable (my "Information") related to my use or potential use of DIACOMIT® to Biocodex, Inc. ("Biocodex") and US Bioservices Corporation ("US Bioservices"), and each of their respective affiliates, representatives, agents, assigns, and contractors (collectively, their respective "Representatives" and, Biocodex and US Bioservices, together with each of their Representatives, collectively, the "Recipients") and authorize the Recipients to use such information to: (1) contact my healthcare provider, insurance company, or other third-party payers about my Information and to use and disclose this Information, and authorize those parties to disclose (ie, release) all such Information to the Recipients to assist in obtaining coverage for DIACOMIT®; (2) provide me with support services for DIACOMIT®; (3) contact me and leave messages about DIACOMIT®; (4) provide me with information or materials related to DIACOMIT® or my relevant medical conditions; and (5) contact me about DIACOMIT®, which may include patient services such as education, training, nurse, and pharmacy support. Each of Biocodex and US Bioservices will, and will cause its Representatives to, maintain the confidentiality of my Information in accordance with its privacy policy and will use this Information only for the purposes described above or as permitted by law. However, I understand that Information disclosed to the Recipients pursuant to this authorization may be subject to re-disclosure, and privacy laws may no longer restrict its use or disclosure. I further understand that I may refuse to sign this authorization and that my refusal to sign this authorization will have no impact on my eligibility to receive health plan benefits or treatments from my healthcare providers, but I will not have access to support services from the Recipients. I understand that I have the right to revoke this authorization at any time in the future, except to the extent that actions have been taken in reliance on the authorization, by submitting a written notice to (i) Biocodex by mail to Biocodex, Inc., #1850 Gateway Drive #175 San Mateo, California 94404 and (ii) US Bioservices via fax to 833-871-4137 or by mail to US Bioservices Corporation, 5025 Plano Parkway, Carrollton, TX 75010. I understand that both Biocodex and US Bioservices must be notified to fully revoke my authorization, and after I have revoked my authorization, the notified Recipient will stop using the personal and medical information already obtained for the purposes of any support services described above. I am entitled to a copy of this authorization, which expires 10 years from the date it is signed by me (unless earlier termination is required by applicable state law).

I have read and agree to the HIPAA Authorization to Share Health Information.

Patient Signature _____ Date _____ / _____ /_____

Legal Guardian/Parent Signature (if applicable) _____ Date _____ / _____ /_____

Legal Guardian/Parent Printed Name (if applicable) _____

Please see full prescribing information before prescribing DIACOMIT® available at:
https://www.diacomit.com/pdf/PI-Diacomit-2018.pdf