Fax completed form to 1-888-668-2143 | For assistance, please contact the OLPRUVA Navigator team at 1-888-668-4198 (Monday to Friday, 8AM - 6PM CST)
Visit OlpruvaHCP.com for Prescribing Information.

AmplifyAssist Prescription Enrollment Form

AmplifyAssist™

OLPRUVA® (sodium phenylbutyrate) for oral suspension

1. Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____ Date of Birth: _____/_____/_____

Gender: ☐ Male ☐ Female ☐ Other: _____(Please provide for identification purposes.)

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Primary Phone Number: _____ ☐ Home ☐ Mobile Best Time to Call: ☐ AM ☐ PM ☐ No preference

Email Address: _____ Preferred Method of Communication: ☐ Phone ☐ Text ☐ Email

Address: _____ City: _____ State:_____ Zip Code: _____

Representative/Caregiver Name : _____ Relationship to Patient: _____ Same Contact Info as Patient: ☐ Yes ☐ No

Primary Phone Number: _____ ☐ Home ☐ Mobile Best Time to Call: ☐ AM ☐ PM ☐ No preference

2. CLINICAL INFORMATION

Primary Diagnosis Code: ☐ Please see attached clinical information for the information requested below.

☐ E72.29 (Carbamylphosphate synthetase) ☐ E72.23 (Citrullinemia / ASS1)

☐ E72.4 (Ornithine transcarbamylase) ☐ E732.20 (Disorder of urea cycle metabolism, unspecified)

Is/Has the patient been treated with a nitrogen scavenger: ☐ Yes ☐ No If yes, please provide product name: _____

Dose: _____ Rationale for switch: _____

Please describe other treatment modalities (e.g. restricted diet):_____

3. INSURANCE INFORMATION (Please provide front and back copy of insurance card(s))

Primary Insurance ☐ Commercial ☐ Medicare ☐ Medicaid

Insurance Carrier Name:_____

Phone Number: _____

Employer Grp/Issuer if available: _____

Phone Number: _____

ID#: _____Group#: _____

Prescription Carrier Name: _____

ID#: _____Group#: _____

Bin#: _____ PCN#: _____

Primary Cardholder Name: _____

Secondary Insurance ☐ Commercial ☐ Medicare ☐ Medicaid

Insurance Carrier Name:_____

Phone Number: _____

Employer Grp/Issuer if available: _____

Phone Number: _____

ID#: _____Group#: _____

Prescription Carrier Name: _____

ID#: _____Group#: _____

Bin#: _____ PCN#: _____

Primary Cardholder Name: _____

4. OFFICE & PRESCRIPTION INFORMATION (Required)

Practice Name: _____ Office Contact Name: _____ Phone#: _____

Fax#: _____Email Address: _____ Preferred Method of Communication: ☐ Phone ☐ Text ☐ Email

Address: _____ City: _____ State:_____ Zip Code: _____

Prescriber First Name: _____ Last Name: _____ Specialty: _____

Tx ID#: _____UPIN/NPI#: _____ License#: _____

Please visit Dosage Calculator for Sodium Phenylbutyrate | OLPRUVA (olpruvahcp.com) to determine the appropriate dose for your patient.

Height: _____ ☐ ft/in ☐ cm Weight: _____ ☐ lb ☐ kg Patient's BSA: _____ m^2 Total Daily Dose: _____mgs

Instructions: Take ☐ 2g ☐ 3g ☐ 4g ☐ 5g ☐ 6g ☐ 6.67g Dose Frequently: ☐ 3x ☐ 4x ☐ 5x ☐ 6x per day

Qty: _____envelopes Days' Supply: _____ Refills: _____Known Drug Allergies: _____

Dispensing Options (choose 1):

☐ Dispense As Written

Prescriber Signature: _____Date: _____

Print Name: _____

☐ Substitution Permitted

Prescriber Signature: _____Date: _____

Print Name: _____

By signing above, I certify that: (1) the medication I prescribe is medically necessary; (2) I have obtained any required consent under federal and state law for the release of the patient's information on this form to Acer Therapeutics Inc. and its contractors and business partners for benefits verification, prior authorization, financial assistance and coordination of dispensing OLPRUVA; (3) I will comply with any and all state-specific and federal prescription requirements and understand non-compliance with these requirements could result in further outreach by the patient's specialty pharmacy; (4) I understand that the information I provide on this form, if signed by the patient, will be used by Acer Therapeutics Inc. and its contractors as authorized by the patient. I authorize: (1) Acer Therapeutics Inc. to forward the prescription above to the applicable pharmacy; (2) Acer Therapeutics Inc. and their partners on behalf of my patient to furnish any information on this form to his/her insurer.

If this section does not comply with your state's prescription laws, please provide us with a compliant prescription.