



Sucraid® (sacrosidase) oral solution Enrollment Form

Phone: 866-740-2743 (CSID) Fax: 866-777-7097

Last Name		First Name		Today's Date		Date Needed	
Home Phone Number ()		Work Phone Number ()		Prescriber		Hospital/Clinic	
Home Address		City	State	Zip	Address		City State Zip
Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home <input type="checkbox"/> Other				Phone Number ()		Fax Number ()	
Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other				Office Contact		Physician Specialty	
Social Security Number			Date of Birth			Preference: <input type="checkbox"/> Fax <input type="checkbox"/> Phone <input type="checkbox"/> Email	
Allergies				Patient Weight <input type="checkbox"/> lbs <input type="checkbox"/> kg		Special Instructions	

INSURANCE INFORMATION (fill out entirely or fax a copy of patient's insurance card, both sides)
PRIMARY INSURANCE: _____
Name of Insured: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____
SECONDARY INSURANCE: _____
Name of Insured: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card #: _____
Statement of Medical Necessity
Primary Diagnosis: _____
ICD-9 Code: _____
Estimated Therapy Start Date: _____
Medical History: _____

PLEASE COMPLETE THE FOLLOWING:
<input type="checkbox"/> SUCRAID® (sacrosidase) oral solution 8500 I.U./ML (2 X 118 ML)
SIG: _____
QUANTITY: 30 day supply (default) Other _____ days supply
REFILLS X : _____ MONTHS
Authorization to Disclose Protected Health Information: By signing below, I hereby authorize CuraScript, Inc. to use and/or disclose protected health information (PHI) related to Sucraid from my health records to QOL Medical LLC, the maker of Sucraid. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to Sucraid Program Manager, CuraScript Inc, 6272 Lee Vista Blvd, Orlando, FL 32822. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. This authorization will remain in effect until revoked by the patient or until the patient is no longer on service with CuraScript. I understand that treatment and/or payment is not conditioned upon the signing of this Authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of information cannot be protected by federal confidentiality rules. If I have questions about disclosures of my health information, I can contact the Privacy Officer at CuraScript, Inc (314-810-3019). I understand that I am entitled to a copy of this authorization.
Signed by Patient: _____ Date: _____
Signed by Legal Representative: _____
Relationship to Patient: _____ Date: _____

PHYSICIAN SIGNATURE REQUIRED TO VALIDATE PRESCRIPTIONS

Physician Signature: _____	UPIN/DEA #: _____	State License#: _____
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