



Mycapssa[®]
(octreotide) capsules
20mg

Prescription Form

Instructions for Prescribers

To prescribe MYCAPSSA for your patient, please follow these steps:

- 1** Complete the Prescription Form and sign and date the Prescriber Authorization. Be sure to complete the mandatory sections of the form (*see reverse side*)
- 2** If available, copy both sides of the patient's insurance card and/or pharmacy benefit card
- 3** Fax the above to 1-833-746-2277

Please advise your patient that they will hear from a MYCAPSSA Amryt Assist Case Manager in 1 to 2 business days. Your office will also receive a confirmation that the form was received.

Fax this form to **1-833-746-2277**

To Be Completed by Prescriber

1: Patient Information* (all fields this section are mandatory)

First Name:	MI:	Last Name:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Last 4 Digits of Social Security #:	
Address:			
City:	State:	Zip:	
Email:	Phone #:		
Caregiver 1 Name:	<input type="checkbox"/> Ok to leave message		
Home:	Cell:	Alternate:	
Email:			
Allergies:	Current Medications:		

No known drug allergies (NKDA)

3: Prescriber Information* (all fields this section are mandatory)

First Name:	MI:	Last Name:	
Prescriber NPI #:	Prescriber Tax ID #:		
Facility Name:			
Facility Address:			
City:	State:	Zip:	
Facility Phone #:	Preferred Fax #:		
Primary Contact Name:	Title/Role:		
Primary Contact Phone #:	Primary Contact Email:		

Prescriber Authorization* (mandatory)

I authorize Amryt 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 MYCAPSSA is for a primary diagnosis of acromegaly and I will be supervising the patient's treatment accordingly.

X

Licensed Prescriber Signature (required – no stamps)

Printed Name

Date

2: Insurance Information* (check the relevant box and complete as much as possible)

Attach a copy of both sides of the patient's insurance card.

Medicare Medicaid Commercial/Private Other Uninsured

Primary Insurance Payer:	Insurance Name:
Phone #:	Policy ID #:
Group #:	BIN:
PCN:	Policy Holder's Name:
Policy Holder's Date of Birth:	Policy Holder's Relationship to Patient:

4: Treatment and Prescribing Information

Patient, at any time, has been prescribed an SSA yes no

ICD-10/Diagnosis: E22.0 (acromegaly and pituitary gigantism)

Other ICD-10/Diagnosis _____

ICD-10/Diagnosis: F40.231 (needle phobia)

Rx Treatment: MYCAPSSA® (octreotide) delayed-release oral capsules NDC: 69880-120-28
Dispense as written.

Please check a box below for medication strength* (mandatory)

MYCAPSSA 40 mg Dosing Schedule

Dispense: MYCAPSSA 20 mg capsules

Sig: Take 1 capsule PO BID

QTY: 56 Number of Refills: _____

MYCAPSSA 60 mg Dosing Schedule

Dispense: MYCAPSSA 20 mg capsules

Sig: Take 2 capsules PO QAM and 1 capsule PO QPM

QTY: 84 Number of Refills: _____

MYCAPSSA 80 mg Dosing Schedule

Dispense: MYCAPSSA 20 mg capsules

Sig: Take 2 capsules PO BID

QTY: 112 Number of Refills: _____

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Please fax this form to 1-833-746-2277. For questions, call 1-833-346-2277.