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**

Mycapssa®
(octreotide) capsules 20mg

Prescription Form

To Be Completed by Prescriber

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

First Name:	MI:	Last Name:
Gender: ☐ Male ☐ Female	Date of Birth:	Last 4 Digits of Social Security #:
Address:		
City:	State:	Zip:
Email:	Phone #:	
Caregiver 1 Name:	❍ Ok to leave message	
Home:	Cell:	Alternate:
Email:		
Allergies:	Current Medications:	

❍ No known drug allergies (NKDA)

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:

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:	

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.

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 MYCAPPSA 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

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

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