DIACOMIT® VA Prescription Form

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

All fields mandatory

1. PATIENT INFORMATION

First Name	Middle Initial	Last Name	Date of Birth (mm/dd/yyyy)	Gender M F
Address				
City			State	Zip Code
Home Phone # OK to leave message	Mobile # OK to text	Best Time to Call	Preferred Language (If other than English)	
Email Address			Pt. Representative/ Caregiver Name	
Relationship	Pt. Rep Phone #	Pt. Rep Email Address		

2. SHIP TO

Check here for direct delivery to patient's shipping address listed above. If the above information is incomplete, the prescription will be shipped to the VA pharmacy listed below.

Care of (If different than Pt.)	City	State	Zip Code

3. VA PHARMACY INFORMATION

VA Name			
Address	City	State	Zip Code
Primary Purchasing Contact	Phone #	Fax #	Email Address
Secondary Purchasing Contact	Phone #	Fax #	Email Address
Primary Clinical Contact	Phone #	Fax #	Email Address
Secondary Clinical Contact	Phone #	Fax #	Email Address
Purchase Order #			

Payment Information Credit Card (call VA contact to obtain) E-invoice via Tungsten Network

4. HEALTHCARE PROVIDER (HCP) INFORMATION

HCP First Name	HCP Last Name	Office/Clinic/ Facility Name	
National Provider ID (NPI) #	State License #	Phone #	
Address	City	State	Zip Code
Office Contact	Contact Phone #	Office Fax #	
Email Address			
Preferred Method of Contact			

5. PRESCRIPTION INSTRUCTIONS (TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY)

DIACOMIT® (stiripentol) (Recommended dose: 50 mg/kg/day, administered in 2 or 3 divided doses (ie, 16.67 mg/kg 3 times daily or 25 mg/kg 2 times daily))

DIACOMIT® (stiripentol) 250 mg capsule NDC 68418-7939-6 250 mg powder for oral suspension NDC 68418-7941-6 500 mg capsule NDC 68418-7940-6 500 mg powder for oral suspension NDC 68418-7942-6	**Quantity**	**Refills**

Dosing (check one) Take mg PO **BID** with food Take mg PO **TID** with food

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®.

Prescriber Signature: Dispense as Written ______ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ______ Date ____ / ____ / ____

Prescriber Signature: Substitution Permitted ______ PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ______ Date ____ / ____ / ____

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

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