

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 <input type="checkbox"/> M <input type="checkbox"/> F
Address				
City			State	Zip Code
Home Phone # <input type="checkbox"/> OK to leave message	Mobile # <input type="checkbox"/> 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			
<input type="checkbox"/> 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 <input type="checkbox"/> Credit Card (call VA contact to obtain) <input type="checkbox"/> 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) <input type="checkbox"/> 250 mg capsule NDC 68418-7939-6 <input type="checkbox"/> 250 mg powder for oral suspension NDC 68418-7941-6 <input type="checkbox"/> 500 mg capsule NDC 68418-7940-6 <input type="checkbox"/> 500 mg powder for oral suspension NDC 68418-7942-6	Quantity	Refills
Dosing (check one) <input type="checkbox"/> Take _____ mg PO BID with food <input type="checkbox"/> 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 _____ <small>PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.</small>	Date _____ / _____ / _____
Prescriber Signature: Substitution Permitted _____ <small>PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.</small>	Date _____ / _____ / _____