



DIACOMIT® Patient Enrollment Form

To help your patient get started on treatment, please fax completed form to 833.871.4137
Phone: 833.248.0467
Hours: M-F, 8AM-8PM (EST)



PATIENT CONTACT INFORMATION

Patient First Name _____				Preferred Language _____			
Patient Last Name _____				Authorized Representative _____			
Sex	Male	Female	Date of Birth	/	/	Relationship to Patient _____	
Address _____							
City	State		Zip		Phone Number and Email for Authorized Representative (if different from above) _____		
Home Phone _____			Mobile _____				
Email _____							

PATIENT INSURANCE INFORMATION *Please complete the following or attach a copy of the front and back of all prescription and medical benefit cards.*

Patient does not have insurance _____									
Primary Medical Insurance _____				Secondary Medical Insurance _____					
Subscriber Name _____									
Relationship to Patient	Self	Spouse	Child	Other	Relationship to Patient	Self	Spouse	Child	Other
Prescription Drug Insurance Provider _____									
ID # _____				BIN # _____					
PCN # _____				Group # _____					
Phone _____									

PRESCRIBER INFORMATION (TO BE COMPLETED BY HEALTHCARE PROVIDER)

Prescriber First and Last Name _____				Prescriber DEA # _____		Prescriber NPI # _____		
Prescriber Specialty _____				Prescriber Phone _____		Prescriber Fax _____		
Practice Name _____								
Address _____								
City	State		Zip		Office Contact Name _____			Phone _____
Email _____								
License # _____	Tax ID: _____	Medicaid Number _____						

CLINICAL INFORMATION (TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY)

(Please attach a list of the patients current medications)

Diagnosis ICD-10
 Dravet syndrome G40.83
 • Polymorphic epilepsy in infancy (PMEI)
 • Severe myoclonic epilepsy in infancy (SMEI)
 Dravet syndrome, intractable, with status epilepticus G40.833
 Dravet syndrome, intractable, without status epilepticus G40.834
 Other Diagnosis (please specify) _____

Is the patient currently taking clobazam? Yes No _____

Is the patient currently taking medication to treat Dravet syndrome? Yes No _____

If yes, provide details _____

Medications Tried and Discontinued

Valproic Acid	Divalproex Sodium	Topiramate	Fintepla	Epidiolex
Other (please specify) _____				
Patient's Current Weight	kgs	Date	/	/
WBC		Date	/	/
Platelet Count		Date	/	/
Known Allergies _____				

(Continued on next page)

PRESCRIPTION INSTRUCTIONS (TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY)

Patient's Name (Last, First) _____ DOB _____ / _____ / _____

DIACOMIT® (stiripentol)

Table 1. Recommended Dosage for Patients 6 Months of Age and Older Weighing 7 kg or More with Dravet Syndrome:

Age of Patient	Body Weight	Dosing Regimen (administered by mouth in equally divided doses)	Total Daily Dose
6 months to less than 1 year	7 kg and above	25 mg/kg twice daily ^{ab}	50 mg/kg/day
1 year and above	7 kg to less than 10 kg	25 mg/kg twice daily ^b	50 mg/kg/day
	10 kg and above	25 mg/kg twice daily or 16.67 mg/kg three times daily	50 mg/kg/day Maximum daily dose is 3000 mg

^a Dosing frequency should not exceed twice daily to limit free water administration.

^b Dosing frequency should not exceed twice daily to avoid overexposures.

DIACOMIT® (stiripentol)

250 mg capsule NDC 68418-7939-6 250 mg for oral suspension NDC 68418-7941-6

500 mg capsule NDC 68418-7940-6 500 mg for oral suspension NDC 68418-7942-6

Quantity

Refills

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

If there is a delay in insurance authorization, Biocodex has designated a Quick Start program, subject to patient eligibility criteria. If you have questions about the program, please call the Biocodex By Your Side Patient Assistance Program at 833-248-0467.

Yes, Specialty Pharmacy to dispense overnight Quick Start 30-day supply to Hospital Pharmacy.

PRESCRIBER ATTESTATION

By signing below, I certify that a) the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed DIACOMIT® (stiripentol), based on my professional judgment of medical necessity for the treatment of Dravet syndrome and b) I have received from the patient identified above, or his/her personal representative, the necessary authorization to release, in accordance with applicable federal and state privacy laws and regulations, referenced medical and/or patient information relating to the need for the above-prescribed therapy to Biocodex, Inc., its affiliates, agents, service providers, representatives, and contractors (collectively, "Biocodex") to use and disclose as necessary for processing and fulfillment of the prescription.

State Requirements: The prescriber is to comply with 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 Signature: Dispense as Written _____ Date _____ / _____ / _____

Prescriber Signature: Substitution Permitted _____ Date _____ / _____ / _____

Please see full prescribing information before prescribing DIACOMIT® available at: <http://www.diacomit.com/PI>