# DIACOMIT® VA Patient Enrollment Form

Fax completed form with prescriber's signature to 833.871.4137
**Phone:** 833.248.0467 | **Hours:** M-F, 8AM-8PM (EST)

All fields mandatory

## PATIENT CONTACT INFORMATION

Patient First Name

Patient Last Name

Sex Male Female Date of Birth / /

Address

City State Zip

Home Phone Mobile

Email

Preferred Language

Authorized Representative

Relationship to Patient

Phone Number and Email for Authorized Representative (if different from above)

Phone Email

## 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 Patient) City State Zip Code

## VA PHARMACY INFORMATION

VA Name

Address

City State Zip

Primary Purchasing Contact

Phone Fax

Email

Secondary Purchasing Contact

Phone Fax

Email

Primary Clinical Contact

Phone Fax

Email

Secondary Clinical Contact

Phone Fax

Email

Purchase Order #

Payment Information

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

## PRESCRIBER INFORMATION (TO BE COMPLETED BY HEALTHCARE PROVIDER)

Prescriber First and Last Name

Prescriber Specialty

Practice Name

Address

City State Zip

License # Tax ID: Medicaid Number

Prescriber DEA # Prescriber NPI #

Prescriber Phone Prescriber Fax

Prescriber Email

Office Contact Name Phone

Email

## 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 myclonic 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)

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## 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<br>16.67 mg/kg three times daily | 50 mg/kg/day<br>Maximum daily dose is 3000 mg |

[a] Dosing frequency should not exceed twice daily to limit free water adminstration.

[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

## 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** ______________________________ (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: **www.diacomit.com/PI**

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