BIOCODEX by your side

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)

DIACOMIT® (stiripentol) 250 mg, 500 mg
capsules or for oral suspension

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

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

Subscriber Name

Relationship to Patient ☐ Self ☐ Spouse ☐ Child ☐ Other

Prescription Drug Insurance Provider

ID # BIN #

PCN # Group #

Phone

Secondary Medical Insurance

Subscriber Name

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 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)

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 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

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 REQUIRED. NO STAMPS.

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

PRESCRIBER SIGNATURE REQUIRED. NO STAMPS.

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