



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)

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 ^{a,b}	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

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: www.diacomit.com/PI