HORIZON UCD
SUPPORT SERVICES

Please fax the completed form to 877-695-8304.

Phone: 855-UCD-SUPT (855-823-7878) **Fax:** 877-695-8304 **www.ucdsupport.com**

UCD SUPPORT SERVICES ENROLLMENT FORM

Patients must also complete the UCD Support Services Patient Enrollment Form for all new referrals.
UCD Support Services is available to all UCD-diagnosed patients regardless of prescription and/or treatment plan.

Patient Information (* Indicates required field)

Patient Name*: ______ DOB*: ___/___/___ Gender*: ☐ Male ☐ Female

Address*: ______ City*: ______ State*: ______ Zip Code*: ______

Preferred Phone*: (___) ______ Alternate Phone: (___) ______ Email: ______

Caregiver/Alternate Contact Name: ______ Relationship: ______ Phone: (___) ______

Preferred Contact: ☐ Patient ☐ Caregiver Preferred Type: ☐ Phone (Day) ☐ Phone (Evening) ☐ Email

☐ Program Enrollment Only (Enrollment Only patients will not receive medication through the program.)

Insurance Information (* Indicates required field) **Please attach copies of insurance card(s), if available.**

Primary Insurance Company*: ______ Phone*: (___) ______

Policy Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other Policy #*: ______ Group #*: ______

Policy Holder Name*: ______ Relationship: ______ DOB: ___/___/___

Secondary Insurance Company: ______ Phone: (___) ______

Policy Type: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Other Policy #: ______ Group #: ______

Policy Holder Name: ______ Relationship: ______ DOB: ___/___/___

Prescription Card?: ☐ Yes If yes, Carrier: ______ Phone: (___) ______

Identification #: ______ Policy/Group #: ______

Policy Holder Name: ______ Relationship: ______ DOB: ___/___/___

Diagnosis Information (**ALL** fields required)

DIAGNOSIS: ☐ Urea Cycle Disorder (270.6) ☐ Other: ______ ☐ Date of Diagnosis (month/year): ______

Specific Disorder: ☐ CPS ☐ OTC ☐ ASS ☐ ASL ☐ ARG ☐ HHH ☐ CITRIN

Patient Weight: ______ lb/kg (circle one) Patient Height: ______ in/cm (circle one) Current Therapy: ______

Prescription Information (Complete all fields if you are prescribing medication for your patient.)

PRESCRIPTION: ☐ RAVICTI® (glycerol phenylbutyrate) Oral Liquid ______ mL/dose ______ Doses/day ______ Total mL/day

Days Supply: ______ Total Quantity (mL): ______ # Refills: ______ Instructions: ______

Prescriber Information (* Indicates required field)

First and Last Name*: ______ Credentials: ______

NPI #*: ______ State License #: ______ State Issued: ______ Tax ID: ______ Specialty*: ______

Practice/Facility Name*: ______ Primary Contact Name: ______

Address*: ______ City*: ______ State*: ______ Zip Code*: ______

Phone*: (___) ______ Fax: (___) ______ Prescriber Email: ______

Prescriber Acknowledgement: I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. I understand that Horizon Pharma plc and its employees or agents (collectively, "Horizon") will use this information to administer the Horizon UCD Support Services program (the "Program"), which provides assistance to patients in obtaining coverage for RAVICTI and assistance in initiating or continuing RAVICTI therapy. By my signature, I also acknowledge that my patient or his or her personal representative has provided a signed HIPAA authorization that allows me to share protected health information with Horizon for purposes of the Program. I appoint the Program, on my behalf, to convey this prescription to the dispensing pharmacy, to the extent permitted under state law. I further understand and agree that (a) any medication or service provided through the Program as a result of this form is for the named patient only and is not being made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use RAVICTI, or any other Horizon product or service, for any other person, (b) my decision to prescribe RAVICTI was based solely on my professional determination of medical necessity, and (c) I will not seek reimbursement for any medication or service provided by or through the Program from any government program or third-party insurer. I understand that Horizon may modify or terminate the Program at any time without notice.

Prescriber Name*: ______ Date: ______

Prescriber Signature*: ______ (Dispense As Written) ______ (Substitution Allowed)

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