

Instructions: FILL OUT and FAX completed form and attachments to 1-855-813-2039.
Call 1-888-760-8330 if you have any questions regarding this form or to contact Pyros Total Care.

1. PATIENT

Please select one: Newly prescribed Patient Patient currently on vigabatrin

Last Name _____ First Name _____ Preferred Language _____ Gender M F

Home Address _____ City _____ State _____ Zip _____

DOB _____ Weight (kg) _____ Height _____ Date of Measurement _____

Parent/Guardian _____ Relation to Patient _____

Home () - _____ Work () - _____ Mobile () - _____

Parent/Guardian Phone (Please check preferred) _____ Phone () - _____ Okay to leave voicemail YES NO

Emergency Contact _____

2. INSURANCE (PLEASE ATTACH COPIES OF FRONT AND BACK OF ALL MEDICAL AND PRESCRIPTION INSURANCE CARDS AS PART OF YOUR FAX)

Medical Plan Name	Prescription Card Name	Secondary Insurance Plan Name
Member #	Phone #	Member #
Group #	Member #	Group #
Policy holder name	Group #	Policy holder name
Relationship to policy holder		Relationship to policy holder

3. PRESCRIBER


Prescriber Name/Title _____ NPI _____ State License # _____

Facility Name _____ Address _____ City _____ State _____ Zip _____

Office Contact Name _____ Phone # _____ Fax # _____

Contact's Email _____ Preferred Contact Method: Phone Email Fax

4. PRESCRIPTION

 **VIGPODER™**
(vigabatrin) for Oral Solution, USP

NDC 80789-117-50

Vigoder (500 mg powder, for oral solution)

SIG: Mix each packet with 10 mLs of water to achieve the correct volume.
(_____ packets needed per dose). **Discard any unused portion.**

Administer _____ mLs (_____ mg) by mouth twice daily.

Instruction _____

Dispense: 30 Days Supply Quantity of Packets: _____ Refill Quantity: _____

5. DIAGNOSIS (PLEASE INCLUDE COPIES OF CLINICAL NOTES)

Please provide the following information:

G40.821, Epileptic spasms, not intractable, with status epilepticus
G40.822, Epileptic spasms, not intractable, w/o status epilepticus
G40.823, Epileptic spasms, intractable, with status epilepticus
G40.824, Epileptic spasms, intractable, w/o status epilepticus

G40.82, Epileptic spasms, Salaam attacks; West's Syndrome
G40.209 Local-related symptomatic epilepsy w/complex partial seizure, not intractable, w/o status epilepticus
Other ICD-10: _____

Allergies _____

I hereby certify that I am prescribing the above medication for the named patient, and I affirm that the therapy described above is medically necessary based on my professional judgment.

Dispense Written _____ Substitution Allowed _____ Date Written _____
(Live Signature Required—Stamped Signatures Are Not Valid) (Live Signature Required—Stamped Signatures Are Not Valid)

6. PATIENT AUTHORIZATION

Please attach separate Patient Authorization as part of your fax.
If the parent/guardian is not present to sign the Patient Authorization, direct them to PTCCConsent.com to sign electronically.