PYROS™ TOTAL CARE

VIGPODER™ Prescription and Enrollment Form

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 ______ ☐ M ☐ F Gender

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)

Emergency Contact ______ Phone ( ) – Okay to leave voicemail ☐ YES ☐ NO

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 # ______

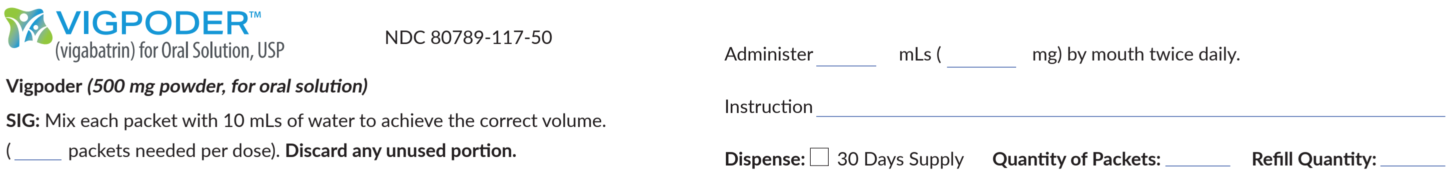
Facility Name ______ Address ______ City ______ State ______ Zip ______

Office Contact Name ______ Phone # ______ Fax # ______

Preferred Contact Method: ☐ Phone ☐ Email ☐ Fax

Contact's Email ______

4. PRESCRIPTION



VIGPODER™ (vigabatrin) for Oral Solution, USP

NDC 80789-117-50

Vigpoder *(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 ______
(Live Signature Required—Stamped Signatures Are Not Valid)

Substitution Allowed ______
(Live Signature Required—Stamped Signatures Are Not Valid)

Date Written ______

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 *PTCConsent.com* to sign electronically.

Scan QR code to get this prescription and enrollment form online.

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