All required fields (marked with *) and signatures must be completed before submitting this form by fax or email.
Fax referral to: 1-888-668-2143 | Email referral to: AmplifyAssist@orsinihc.com
Call AmplifyAssist at 888-668-4198 for more information | Hours: 8 am–6 pm CT, Monday–Friday

AmplifyAssist™ Enrollment Form

1. PATIENT INFORMATION

*First Name: ______ Middle Initial: ______ *Last Name: ______ Date of Birth: ____ / ____ / ____

Gender: ☐ Male ☐ Female ☐ Other: ______ (Please provide for identification purposes.)

Primary Language: ☐ English ☐ Spanish ☐ Other: ______

*Primary Phone Number: ______ ☐ Home ☐ Mobile Best Time to Call: ☐ AM ☐ PM ☐ No preference

*Email Address: ______ Preferred Method of Communication: ☐ Phone ☐ Text ☐ Email

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

Representative/Caregiver Name: ______ Relationship to Patient: ______ Same Contact Info as Patient: ☐ Yes ☐ No

*Primary Phone Number: ______ ☐ Home ☐ Mobile Best Time to Call: ☐ AM ☐ PM ☐ No preference

2. CLINICAL INFORMATION

*Primary Diagnosis Code: ☐ Please see attached clinical information for the information requested below.

☐ E75.24 = Niemann-Pick disease ☐ E75.242 = Niemann-Pick disease type C

☐ E75.249 = Niemann-Pick disease, unspecified ☐ Other: ______

Is/Has the patient been treated with miglustat? ☐ Yes ☐ No Dose: ______ ☐ Participant/Participated in Zevra Expanded Access Program

3. INSURANCE INFORMATION (Please provide front and back copy of insurance card(s))

Primary Insurance ☐ Commercial ☐ Medicare ☐ Medicaid

Insurance Carrier Name: ______

Phone Number: ______

Employer Grp/Issuer if available: ______

Phone Number: ______

ID#: ______ Group#: ______

Prescription Carrier Name: ______

ID#: ______ Group#: ______

Bin#: ______ PCN#: ______

Primary Cardholder Name: ______

Secondary Insurance ☐ Commercial ☐ Medicare ☐ Medicaid

Insurance Carrier Name: ______

Phone Number: ______

Employer Grp/Issuer if available: ______

Phone Number: ______

ID#: ______ Group#: ______

Prescription Carrier Name: ______

ID#: ______ Group#: ______

Bin#: ______ PCN#: ______

Primary Cardholder Name: ______

4. OFFICE AND PRESCRIPTION INFORMATION

***Prescriber First Name:** ______ ***Last Name:** ______

***Institution/Hospital Name:** ______ ***NPI:** ______

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

***Phone:** ______ ***Ext:** ______ ***Fax#:** ______

***Office Contact Completing This Form:** ______ ***Email:** ______

***Recommended Dosing Guidelines:** Please see **Prescribing Information** for dosing considerations in special populations.

Patient Body Weight		Recommended Dosage
8–15 kg	17.6–33 lb	47 mg three times a day
>15–30 kg	>33–66 lb	62 mg three times a day
>30–55 kg	>66–121 lb	93 mg three times a day
>55 kg	>121 lb	124 mg three times a day

Product capsules may be swallowed whole or the contents of the capsule can be added to a suitable beverage, soft food, or added to water to allow administration via a feeding tube.

***Patient Weight** ______ **kg or** ______ **lb**

***Prescription:**

☐ 47 mg (NDC: 72542-147-01)
☐ 62 mg (NDC: 72542-162-01)
☐ 93 mg (NDC: 72542-193-01)
☐ 124 mg (NDC: 72542-124-01)
☐ Other: ______

***Dispense:**

☐ #90 capsules ☐ Other: ______

***Refills:**

☐ #90 capsules ☐ Other: ______

***SIG:**

☐ Take one capsule by mouth three times daily
☐ Other: ______

***Prescriber Signature (Dispense as written):** ______ ***Date:** ______

***Prescriber Signature (Substitution permitted):** ______ ***Date:** ______

I certify that I have prescribed MIPLYFFA as described above based on my professional judgment of medical necessity. I authorize the release of medical and/or other patient information relating to MIPLYFFA therapy to Zevra Therapeutics, Inc., its agents, and Service Providers (including, but not limited to, MIPLYFFA-dispensing pharmacies) to use and disclose as necessary for prior authorization processing and fulfillment of the prescription.

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