

CYSTADANE®
(betaine anhydrous for oral solution) powder
Prescription Order Form

Please select one: **Newly Prescribed Patient** **Patient Currently on Cystadane®**

Patient Information <small>*Please print</small>	Last Name:		First Name:		SSN:		Sex: M F	
	Address:				City:		State:	Zip:
	Phone: Day #			Evening #:		Cell # :		
	DOB:		Ht: ft. in.	Wt: lbs.		Date Weight Taken:		
	If Patient is a Minor, Guardian/Parent Name:					Relation to Patient:		
	Emergency Contact:					Phone #:		

Insurance Information <small>*Include copies of insurance cards</small>	Primary Insurance Co. Name:						Phone #:	
	Policy Holder Name:				Policy #:		Group #:	
	Prescription Card Name:						Phone #:	
	Policy #:						Group #:	
	Secondary Insurance Co. Name:						Phone #:	
	Policy Holder Name:				Policy #:		Group #:	

Physician Information	Prescriber Name/Title:							
	NPI:		DEA:		Medicaid UPIN:		State License #:	
	Address:							
	City:				State:		Zip:	
	Name of Contact Person:						Phone:	
	Physician Email:						Fax:	

Prescription	CYSTADANE® (betaine anhydrous for oral solution) powder 1 bottle = 180 grams							
	Sig: Dissolve _____ scoop(s) in 4–6 ounces (120-180mL) of water, juice, milk, or formula, or mixed with food for immediate ingestion. (Note: 1 scoop = 1 gram)							
	Solution should be taken _____ time(s) daily. Quantity to dispense _____ bottles.							
	Refills _____							
PLEASE NOTE: Because Cystadane is only supplied in bottles containing 180 grams, the actual day's supply provided by one bottle of Cystadane will vary depending on the patient's daily dose. Cystadane is not available in amounts smaller than 180 grams per bottle.								

Medical Necess	Primary diagnosis:				Date of Diagnosis :		Patient Age at Diagnosis:	
	Please check applicable ICD-10 code:							
	Homocystinuria (E72.11)		Methylmalonic Acidemia with Homocystinuria (E71.120)		MTHFR Deficiency (E72.12)			
	Methylcobalamin deficiency (E53.8)		Other (please specify)					
Therapy Start Date:								
Allergies								
NKDA								

I certify I am prescribing CYSTADANE® for this patient for a medically necessary purpose. Date Written: _____

Dispense as Written: _____
(Stamped Signatures Are Not Valid)

Substitution Allowed: _____
(Stamped Signatures Are Not Valid)

This Prescription Form is only valid if FAXED to Anovo @ 855-813-2039