anovoRx

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

Fax: 855-813-2039
Phone: 888-487-4703

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

Patient Information **Please print*

Last Name: First Name:		SSN:	Sex: ☐ M ☐ F
Address:	City:	State:	Zip:
Phone: Day # ( )	Evening #: ( )	Cell # : ( )	
DOB: Ht: Wt:		Date Weight Taken: _____	
If Patient is a Minor, Guardian/Parent Name:		Relation to Patient:	
Emergency Contact:		Phone #: ( )	

Insurance Information **Include copies of insurance cards*

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) 1 bottle = 180 grams

Sig: Dissolve _____ scoop(s) in 4–6 ounces of water, juice, milk, or formula, and drink solution immediately.
(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 Necessity

Date of Diagnosis :	Patient Age at Diagnosis:

Primary ICD-10 code _____ Please check one: ☐ Homocystinuria (E72.11) _____ ☐ Other (ICD-10)_____

☐ Other (E53.8) _____ ☐ Other (E71.120)_____ ☐ Other (E72.12)_____ 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 AnovoRx Group, LLC @ 855-813-2039

Form: CYS.RX.01
Effective Date: 07/01/2014; Revised 09/24/15