CYCLE VITA
Support for life

Patient Enrollment Form for ORMALVI™ (dichlorphenamide) Tablets

Phone: +1 (888) 360-8482 FAX: +1 (888) 385-8482

ORMALVI™ (dichlorphenamide) tablets

To Enroll, fax this form: + 1 (888) 385-8482

Or email: hello@cyclevita.life

All required fields are purple and noted with an asterisk*

PATIENT INFORMATION

Patient Last Name*		Patient First Name*
Date of Birth*	Gender* ☐ Male ☐ Female ☐ Other	
Parent/Guardian Name *(if patient is a minor) / Caregiver Name*	Relationship to Patient	Power of Attorney/Medical Proxy ☐ Yes ☐ No
Street Address*		Suite/Floor/Apt #
City*	State*	Zip code*

Preferred Method of Contact (please specify)*

☐ Cell Phone ☐ Alternate Phone

☐ Email

Language Preferred* ☐ English ☐ Spanish ☐ Other (please specify):

PRESCRIBER INFORMATION

Prescriber Last Name*		Prescriber First Name*
Prescriber Office/Site/Clinic*		
Prescriber Phone Number*		Prescriber Fax Number*
Street Address*		
City*	State*	Zip Code*
NPI Number*		
Office Contact Name*		
Office Contact Phone Number with extension*		Office Email Address*

INSURANCE INFORMATION

Please attach a copy of the prescription insurance benefit card, front and back, or complete the following*

☐ Prescription insurance benefit card attached ☐ Patient does not have insurance ☐ Patient requires Co-Pay only

Primary Insurance Company Name*		Secondary Insurance Company Name	
Primary Insurance Company Phone Number*		Secondary Insurance Company Phone Number	
Name of Primary Cardholder*		Name of Primary Cardholder	
Primary Insurance Member ID*	Group ID*	Secondary Insurance Member ID	Group ID
BIN*	PCN*	BIN	PCN

Prior Authorization Status*

☐ Submitted ☐ Not submitted ☐ Approved ☐ Denied

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Patient Full Name*	Date of Birth*

CLINICAL INFORMATION

Has this patient been diagnosed with Primary Periodic Paralysis (PPP)?* ☐ Yes ☐ No

If the patient has not been diagnosed with PPP:
Only patients who have been diagnosed with PPP can start ORMALVI.

If the patient has been diagnosed with PPP:
Type of Primary Periodic Paralysis*
☐ Hyperkalemic ☐ Hypokalemic ☐ Other (please specify): _____
How was diagnosis reached?* ☐ Genetic testing ☐ Other (please specify): _____

Diagnosis ICD-10-CM* ☐ G72.3 ☐ G71.19 ☐ Other (please specify): _____

Patient history with dichlorphenamide*
☐ Has never been prescribed dichlorphenamide ☐ Is currently prescribed dichlorphenamide ☐ Other (please specify): _____

Patient Allergies*: ☐ None Known ☐ Known (please list known allergies): _____

Patient Medications*: ☐ None ☐ Please list the names of any other health conditions the patient currently has (if any):

PRESCRIPTION INFORMATION

☐ ORMALVI (dichlorphenamide) 50 mg tablets*	NDC Number: 70709-085-10

Only prescriptions filled with the product NDC number listed above will be eligible for Cycle Vita (Eligible Programs).*

Quantity: _____ tablets

Per days supply: ☐ 30 days ☐ 60 days ☐ 90 days ☐ _____ (other)

Number of Refills: _____

Initiate dosing at 50 mg by mouth once or twice daily. The dosage may be increased or decreased based on individual response, at weekly intervals (or sooner in case of adverse reaction). The minimum recommended total daily dosage is 50 mg, and the maximum recommended total daily dosage is 200 mg.

Patient Directions (check all that apply)*

☐ Take _____ 50 mg ORMALVI (dichlorphenamide) tablets, _____ daily, for a total dose of _____ mg/day.

☐ Please contact your physician before starting use of the medication.

☐ Other (please specify): _____

Shipping Instructions (check if applicable): ☐ Dispensing pharmacy to notify prescriber when initial shipment is scheduled.

☐ Bridge Program† - "Bridge" is a FREE supply of ORMALVI that allows patients diagnosed with PPP to begin therapy immediately while Cycle Vita secures appropriate benefit verification and authorization. "Bridge" may also be requested for existing patients who are temporarily experiencing disruption in therapy due to insurance coverage.*

By checking the box above for Bridge, I, as the prescriber, with my signature below on this form, agree and attest that I will not submit a claim to or seek payment from the patient or any third-party payer (e.g., Medicaid, Medicare, private insurance, etc.) for payment/reimbursement for any free product(s) provided by Cycle Vita. I agree and understand that any free product provided by Cycle Vita may not be sold, traded, bartered, transferred, or returned for credit and will only be used for the patient named above on this form. Cycle Vita reserves the right to modify or terminate the program without notice at any time.

†Bridge is at no cost, for eligible patients within labeled indication only, and not contingent on purchase of any kind. Bridge is intended to support continuation of prescribed therapy if there is any disruption in therapy due to insurance coverage.

PRESCRIBER DECLARATION

Prescriber Declaration: I understand and agree that, as the prescriber, I will comply with my state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to me, as the prescriber. I verify that the patient and prescriber information contained in this enrollment form is complete and accurate to the best of my knowledge and that I have prescribed ORMALVI based on my professional judgment of medical necessity. I authorize Cycle Vita, its affiliates, agents, and contractors (collectively, "Cycle Vita") to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the above-named patient utilizing their benefit plan. I authorize Cycle Vita, its affiliates, agents and contractors to perform any steps necessary to secure reimbursement for ORMALVI, including but not limited to insurance verification and case assessment. I understand that Cycle Vita may need additional information, and I agree to provide it as needed for the purposes of securing reimbursement.

Prescriber Signature (please select one of the options below)*‡

X _____	X _____	_____
Prescriber Signature/Dispense as Written (DAW)* (no stamps or initials)	Prescriber Signature/Substitution Permitted (no stamps or initials)	Date of Signature* (MM/DD/YYYY)

‡Certain states require the prescriber to handwrite "brand medically necessary" or other such language, if determined independently by the prescriber in their clinical option. State requirements: E-prescribing, state-specific prescription forms, fax language etc. must be complied with by the prescriber. In the case of noncompliance with state-specific requirements, outreach to the prescriber may occur.

This form is not considered a valid prescription in Alabama. This form is not considered a valid prescription in New York. Prescribers in the State of New York are required to send prescriptions using escript.

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