Sephience™ Prescription Start Form

Contact us: 1-844-4PTCCARES (1-844-478-2227)

Fax or Email Completed Form to:
1-908-912-9015 or SephienceSupport@PTCCares.com

Step 1: Complete Patient Information.
Step 2: Complete Insurance Information section OR attach copy of insurance card/details.
Step 3: If possible, obtain patient or parent/guardian signature for the Patient Direction and Consent for PTC *Cares*™ Program Participation section. (This is not required for form to be complete).
Step 4: Complete ALL portions of Page 2: Clinical Information/Diagnosis, two prescriptions, and two signatures.
Step 5: Fax or email this form, along with copies of both sides of insurance and prescription benefit cards (if possible) to PTC *Cares* at 1-877-204-2180 or SephienceSupport@PTCCares.com.

Patient Information

Patient First	Middle	Last
Date of Birth MM / DD / YYYY	Gender ☐ F ☐ M ☐ Other	
Address	City	Postal Code State
Parent/Legal Guardian (If applicable) Full Name		Relationship to Patient
Primary Language ☐ English ☐ Spanish ☐ Other		Email Address
Home Phone ☐ OK to leave message		Cell Phone ☐ OK to leave message
Preferred Method of Contact ☐ Email ☐ Phone ☐ Text		Best time to reach me ☐ Morning ☐ Afternoon ☐ Evening

Insurance Information

	Primary Insurance	Secondary Insurance
Insurance Name		
Member ID		
Policyholder Name		
Rx Member ID		
Rx BIN or PCN (if applicable)		
Rx Group ID		
☐ Patient has no insurance		
☐ Included copy front/back of prescription, medical, secondary insurance cards		

Patient Direction and Consent for PTC *Cares*™ Program Participation (Optional)
I understand that I am making this request to hereby direct my healthcare providers, pharmacies, designated treatment centers, and health plans to disclose health information that is related to my use or potential use of SEPHIENCE™ (sepiapterin), including my health conditions, diagnosis and treatment that are related to my use or need for SEPHIENCE™ and any inferences that may be drawn from this information (my "PHI" or "Health Information") to PTC Therapeutics US, Inc. and its affiliates, agents and contractors (together "PTC"), and to my pharmacies and designated treatment centers. I understand and agree that the purpose of my request is for PTC and my pharmacies or designated treatment center to use and disclose my PHI—which when used or disclosed by PTC may be considered to be Sensitive Data and/or Consumer Health Data under the laws of some states—to enroll me in the PTC *Cares*™ Program, which includes the following services, which I've requested (the "PTC *Cares*™ Program" or "Program"): 1) determining my benefit eligibility for SEPHIENCE™; 2) communicating with my healthcare providers and health plans about benefits, coverage and medical care; 3) providing me with support services for SEPHIENCE™; and 4) to contact me, leave me messages, and/or provide me with information or materials related to SEPHIENCE™, my relevant medical conditions, and/or the Program, which may include patient services such as education, training, nurse, and pharmacy support. To the extent permitted by local regulations, the Program may be utilizing artificial intelligence (AI) to increase quality, to expedite the review process, and to improve user experience. I understand that this is completely voluntary for me and I may decide not to sign this Direction and Consent and that my refusal will have no impact on my eligibility to receive health plan benefits or treatments from my healthcare providers, but I will not have access to support services from the PTC *Cares*™ Program. I understand that I may terminate or revoke this direction and consent to my healthcare providers to disclose my PHI and/or revoke my consent for the continued collection and processing of my Sensitive Data/Consumer Health Data in connection with the Program, at any time by submitting a written notice to PTC Therapeutics via fax to 1-908-222-7231 or by mail to PTC Therapeutics. **Attention:** Compliance Officer, PTC Therapeutics, 500 Warren Corporate Center Drive, Warren, NJ 07059. I understand that my termination/revocation will not impact any use or disclosure or other processing activities with my Health Information undertaken by PTC, my pharmacies or designated treatment centers before PTC received my termination/revocation and that my termination/revocation will mean that I will no longer receive support services from the Program. This Direction and Consent will continue until I terminate or it otherwise expires 5 years from the date it is signed by me. I understand that my pharmacy and designated treatment centers may receive remuneration in exchange for the use and sharing of my information pursuant to this Direction and Consent. Information disclosed pursuant to this Direction and Consent may be used or disclosed by the recipient and no longer protected by the federal HIPAA privacy rules. However, the recipients of the Information agree to only use and disclose it as stated in this Direction and Consent or as otherwise allowed or required by law. I understand I can access PTC's Privacy Statement and Consumer Health Data Statement at PTCBio.com, which also includes a description of my privacy rights. California residents can visit https://ptcprivacy.com/#privacy-statement-for-california-residents. The personal insurance and information I have provided on this form are complete and accurate to the best of my knowledge. I will update my information promptly if any of the information reflected on this form changes by contacting PTC *Cares*™ at 1-844-478-2227.

Patient or Parent/Guardian Signature	Full Name
Relationship	Date

If completed electronically: *I understand that my act of providing the information and submitting this form is my electronic signature for this request.*

Please see **www.SEPHIENCE.com** for full Prescribing Information

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To Be Completed by Healthcare Provider

Patient First Name	MI	Patient Last Name	Date of Birth / /

Clinical Information/Diagnosis

Primary ICD-10 ☐ E70.0 (Classical PKU) ☐ E70.1 (Other Hyperphenylalanemias-PKU) | Allergies | Check if none ☐

Check all previous pharmacological therapies used to manage Phenylketonuria (PKU) and dates taken (month and year)

☐ Sapropterin (Kuvan®/Generic)	Start MM/YY	End MM/YY	Currently on Therapy ☐	☐ None/ Treatment Naive
☐ Pegvaliase (Palynziq®)	Start MM/YY	End MM/YY	Currently on Therapy ☐	☐ Other, please specify:

Prescription Information (Complete and Sign BOTH prescriptions)

Current weight kg	Dose per kg body weight mg/kg/day	☐ Other mg/kg/day

Patient Assistance Program Prescription for SEPHIENCE™ (sepiapterin)

Number of days supply/prescription: ☐ 90 days ☐ 30 days

Patient Directions:

☐ Take _____ 250 mg Sephience (oral powder) once daily, as directed, with a meal, for a total dose of _____ mg/day.	NDC: 52856-201-03	Number of Refills ☐
☐ Take _____ 1000 mg Sephience (oral powder) once daily, as directed, with a meal, for a total dose of _____ mg/day.	NDC: 52856-301-03	Number of Refills ☐

☐ Other

Prescription for SEPHIENCE™ (sepiapterin) - Specialty Pharmacy

Number of days supply/prescription: ☐ 90 days ☐ 30 days

Patient Directions:

☐ Take _____ 250 mg Sephience (oral powder) once daily, as directed, with a meal, for a total dose of _____ mg/day.	NDC: 52856-201-03	Number of Refills ☐
☐ Take _____ 1000 mg Sephience (oral powder) once daily, as directed, with a meal, for a total dose of _____ mg/day.	NDC: 52856-301-03	Number of Refills ☐

☐ Other

Prescriber Information

Prescriber Full Name		Institution Name		
Address		City	State	Zip
Phone	Fax	NPI#	DEA#	Tax ID#
Office Contact Name		Phone	Best time to contact ☐ Morning ☐Afternoon	
Office Contact Email				

Prescriber Authorization*:

By signing the Start Form, I certify that I have prescribed SEPHIENCE™ (sepiapterin) as described above based on my professional judgment of medical necessity. I authorize the release of medical and/or other patient information relating to SEPHIENCE therapy to PTC Therapeutics, its agents and service providers (including, but not limited to SEPHIENCE-dispensing pharmacies) to use and disclose as necessary for prior authorization processing and fulfillment of the prescription. I authorize PTC *Cares*™ to initiate any de minimis authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited. ***NY Prescribers:** must also submit an electronic prescription.

Prescriber Authorization Signature (No Stamp Allowed) _____ **Date** _____

Substitution Preference Signature _____ Substitution Allowed Date _____ Substitution Not Allowed Date _____

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