



# Wilson's Disease Enrollment & Prescription Form

P: 1-844-443-6879 F: 1-844-329-2447

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name _____	Prescriber's Name _____
DOB ___/___/___ SSN _____ Gender _____	Group Practice or Hospital Name _____
Weight _____ Height _____ Phone _____	State License# _____ UPIN _____
Address _____	DEA _____ NPI _____
City, State, Zip _____	Address _____
Cell Phone _____ E-Mail _____	City, State, Zip _____
Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Prescriber's Office <input type="checkbox"/> Discount Drug Mart	Phone _____ Fax _____
	Office Contact Person _____
	Prescription Date _____ Date Needed _____
	Physician Signature _____

**Prescription Insurance Information** (please provide copy of patient's prescription insurance card with enrollment form)

Primary Insurance Name _____	Secondary Insurance Name _____
Primary Insurance Phone _____ Group# _____	Secondary Insurance Phone _____ Group# _____
Policy Holder Name _____	Policy Holder Name _____
Policy Holder Employer _____	Policy Holder Employer _____
Relationship to Patient _____	Relationship to Patient _____
ID# _____ RxBIN _____ PCN _____	ID# _____ RxBIN _____ PCN _____

**PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES**

**Medical Information (DO NOT COMPLETE IF CHART NOTES ARE PROVIDED)**

**Diagnosis Information**

E83.01 - Wilson's Disease      Diagnosis Date \_\_\_/\_\_\_/\_\_\_

Previous Therapy (if applicable): \_\_\_\_\_

**PRESCRIPTION INFORMATION**

**ADULT DOSE**

**CLOVIQUE™ 250mg Capsule (NON-REFRIGERATED blister packs of 12 capsules each)**

750 – 1250 mg/day PO, divided       BID; NOT to exceed 2000 mg/day      QTY: \_\_\_\_\_      Refills \_\_\_\_\_

TID

QID

Other: \_\_\_\_\_      QTY: \_\_\_\_\_      Refills \_\_\_\_\_

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**Trientine 250mg Capsule**

750 – 1250 mg/day PO, divided       BID; NOT to exceed 2000 mg/day      QTY: \_\_\_\_\_      Refills \_\_\_\_\_

TID

QID

Other: \_\_\_\_\_      QTY: \_\_\_\_\_      Refills \_\_\_\_\_

**PEDIATRIC DOSE**

**CLOVIQUE™ 250mg Capsule (NON-REFRIGERATED blister packs of 12 capsules each)**

< 12 years old: 500 – 750 mg/day PO, divided       BID; NOT to exceed 1500 mg/day      QTY: \_\_\_\_\_      Refills \_\_\_\_\_

TID

QID

Other: \_\_\_\_\_      QTY: \_\_\_\_\_      Refills \_\_\_\_\_

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**Trientine 250mg Capsule**

< 12 years old: 500 – 750 mg/day PO, divided       BID; NOT to exceed 1500 mg/day      QTY: \_\_\_\_\_      Refills \_\_\_\_\_

TID

QID

Other: \_\_\_\_\_      QTY: \_\_\_\_\_      Refills \_\_\_\_\_

CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.