



A. Prescriber information

First name		Last name		Specialty	
Address			Phone	Ext.	Fax
City	State	Zip	Office/Clinic/Institution name		
State license #		Prescriber tax ID (Optional)		NPI #	
Primary contact name		Phone		Email	
Preferred specialty pharmacy (selection will be honored if permitted by patient's insurance) <input type="radio"/> Accredo <input type="radio"/> Frontier Therapies – Optum <input type="radio"/> PantherRx					

B. Patient information

					Preferred language	
First name		Middle initial	Last name		Date of Birth / / <input type="radio"/> Male <input type="radio"/> Female	
Home phone		Work Phone		Email	Address	
Parent/guardian first and last name (if applicable)			Relationship	Email		Cell
				Preferred contact <input type="radio"/> Email <input type="radio"/> Phone <input type="radio"/> OK to leave message		
Parent/guardian 2 first and last name (if applicable)			Relationship	Email		Cell
				Preferred contact <input type="radio"/> Email <input type="radio"/> Phone <input type="radio"/> OK to leave message		

Prescription drug information *Attach copies of both sides of the patient's pharmacy benefit card*

Check if no coverage (If no coverage is determined, the patient will be considered for the Patient Assistance Program)

Prescription insurance information *Attach copies of both sides of the patient's insurance card(s)*

Primary insurance name		Policy holder name		Date of Birth / /	
Insurance company phone		Policy #	Group #	Last 4 digits of patient SSN	
Secondary insurance name		Policy #		Group #	
Pharmacy Benefit Manager		RxBIN	RxPCN	RxGroup	RxID

C. Prescription for Bylvay™ (odevixibat) *See Dosing Tables to determine dosage by patient weight in kg*

Medication	Strength—Check box of requested dose	Directions†	Quantity	Days Supply	Refills
Bylvay™	<input type="checkbox"/> 200mcg oral pellets for sprinkle only*	<input type="checkbox"/> Sprinkle/mix with/over food ____ mcg total once daily <input type="checkbox"/> Take ____ mcg total swallowed whole once daily			
	<input type="checkbox"/> 600mcg oral pellets for sprinkle only*				
	<input type="checkbox"/> 400mcg capsule**				
	<input type="checkbox"/> 1200mcg capsule**				

*200mcg and 600mcg strengths must be opened and sprinkled, NOT swallowed whole
**400mcg and 1200mcg strengths can be opened and sprinkled OR swallowed whole

†Daily Dose must be a multiple of the listed strengths

Current weight: ____ kg (Date measured: ____/____/____)

Prior Authorization # if known: _____ Prior Authorization Effective Dates: _____
Additional Considerations: _____ Drug/Food Allergies: _____ No Known Drug Allergies
Concurrent Medications: Ursodeoxycholic Acid Rifampicin Other

Prescriber authorization

I authorize Albireo Pharmaceuticals, Inc. and its agents as my designated agent and on behalf of my patient to (1) forward this statement of medical necessity to furnish any information on this form to and recruit necessary patient information from the insurer of above-named patient and (2) forward this prescription, by any means under applicable law, fax or other mode of delivery, to the pharmacy. I certify that the rationale for prescribing Bylvay™ is for a primary diagnosis of PFIC and I will be supervising the patient's treatment accordingly. **CA, MA, NC & PR:** Interchange is mandated unless Prescriber writes the words "No Substitution." **ATTN: NY and IA providers,** please submit electronic prescription **Please select 1 option and sign only once below.**

PREScriBER'S SIGNATURE (dispense as written). Signature stamps not acceptable.

PREScriBER'S SIGNATURE (substitution permitted). Signature stamps not acceptable.

/ /

DATE

Albireo makes no representation that the information will comply with the requirements of any particular payer/insurer. The use of this information does not guarantee payment or that any payment received will cover your costs. Special note: The physician is to comply with their state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance of state-specific requirements could result in outreach to the prescriber.

Clinical information *(Please include the patient's most recent chart notes)*

Primary diagnosis: progressive familial intrahepatic cholestasis (PFIC) ICD-10:	
1. When was the patient first diagnosed with PFIC (month/year) /	2. Has the patient had genetic testing? <input type="radio"/> Yes <input type="radio"/> No
3. Severity of pruritus <input type="radio"/> Mild <input type="radio"/> Moderate <input type="radio"/> Severe	

