Bylvay (odevixibat) 200 | 400 | 600 | 1200 mcg capsules

Albireo Assist™ Enrollment Form

Call 855-ALBIREO with questions about properly completing this form.

A. Prescriber information

First name	Last name		Specialty	
Address			Phone	Ext.	Fax
City	State	Zip	Office/Clinic/Institution name	
State license #		Prescriber tax ID		NPI #
Primary contact name		Primary contact phone		Primary contact email

B. Patient information

First name	Middle initial	Last name	Preferred Contact Language	
Parent/guardian first name (if applicable)			Date of Birth / /	❍ Male ❍ Female
Parent/guardian last name (if applicable)			Relationship	Email
Parent/guardian 2 first name (if applicable)			Preferred contact ❍ Email ❍ Phone ❍ OK to leave message	
Parent/guardian 2 last name (if applicable)			Relationship	Email
Home phone	Cell	Work	Preferred contact ❍ Email ❍ Phone ❍ OK to leave message	
			Address	

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			Insurance company phone	
Policy #			Group #	
Policy holder name	Date of Birth / /		Last 4 digits of patient SSN	
❍ Check if patient has secondary insurance				
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	Quantity	Days Supply	Refills	Directions†
❍ Bylvay	❍ 200mcg for sprinkle only*				❍ Sprinkle/mix with/over food _____ mcg total once daily
	❍ 600mcg for sprinkle only*				
	❍ 400mcg**				❍ Take _____ mcg swallowed whole total once daily
	❍ 1200mcg**				

*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 ICD-10:

1. When was the patient first diagnosed with PFIC (month/year) /	**4.** Fasting sBA µmol/L
2. Has the patient had genetic testing? ❍ Yes ❍ No	**5.** PEBD ❍ Yes ❍ No Post liver transplant ❍ Yes ❍ No
3. Severity of pruritus ❍ Mild ❍ Moderate ❍ Severe	

AlbireoAssist™ Personalized Support Services HELPING NAVIGATE THE WAY

By fax: 866-853-0479