CSID DOCTOR DISCUSSION GUIDE

Your Name: _____ **Date:** _____

Preparing for your next doctor visit? Discussing your GI symptoms can be challenging, especially trying to remember everything you want to say. Don't be shy. This simple guide is designed to help!

Key questions to ask

- Could something I'm eating cause my symptoms?
- Could the sugar (sucrose) in my diet or medications be part of it?
- Is it possible I have a GI condition?
- Could it be **CSID (Congenital Sucrase-Isomaltase Deficiency)?**
- Are there diagnostic tests I can take?
- What could I do to improve my symptoms?
- What are my treatment options?

Discuss the symptoms below with your doctor

I Have Been Experiencing:	Almost always	Often	Occasionally	Never
1. Bloating	◯	◯	◯	◯
2. Stomach cramps	◯	◯	◯	◯
3. Excessive gas	◯	◯	◯	◯
4. Frequent diarrhea	◯	◯	◯	◯
5. Loose stools	◯	◯	◯	◯
6. Unexplained weight change	◯	◯	◯	◯
7. Sudden urge to use the bathroom	◯	◯	◯	◯
8. Going to the toilet for a long time	◯	◯	◯	◯
9. Symptoms after eating sweet, sugary foods	◯	◯	◯	◯
10. Symptoms after eating	◯	◯	◯	◯

Information for your doctor

CSID is a rare genetic disease that causes malabsorption of sucrose and starches. CSID should be part of the differential diagnosis when a patient presents with chronic complaints of postprandial diarrhea, excess gas, and abdominal distention and cramping. CSID is mainly a clinical diagnosis. There are a number of diagnostic tests that can aid in diagnosing sucrase insufficiency. Other factors can cause sucrose intolerance; a positive test may be something other than CSID. False positives and false negatives can occur.

Print this guide and bring it with you to your doctor. The Doctor Discussion Guide is intended for informational purposes only and should not be used as a substitute for advice provided by your doctor or other healthcare professionals. Please do not use the Doctor Discussion Guide for diagnosing a health problem or disease. You should always consult your doctor or other healthcare professionals.

DTP SUC25.3060

Please complete and fax this prescription form to **1-866-850-9155**. Need Help? Frontier Therapies – Optum 1-833-800-0122

Sucraid® (sacrosidase) Oral Solution

FREE 4-DAY TRIAL AND PRESCRIPTION FORM | 4DT

1 PATIENT INFORMATION

First Name:	Address:
Last Name:	City:
DOB: / /	State:
Gender: ☐ Male ☐ Female	Zip:
Email:	Preferred Language:
Preferred Phone:	Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

2 INSURANCE INFORMATION

☐ Patient does not have insurance	**Medical Insurance Name:**	**Pharmacy Insurance Name:**
Phone:	Member ID #:	Phone: Pharmacy ID:
Policyholder Name & DOB: / /		BIN: PCN: Group#:

☐ **See secondary insurance information attached.** (**NOTE:** Be sure to include secondary insurance information when sending back these forms)

3 MEDICAL HISTORY (PLEASE INCLUDE ICD-10 CODE)

Diagnosis Code Category: ☐ Diagnosis ICD-10-CM **Code E74.31**	☐ Other Diagnosis:	Allergies:	Current Medications:

4 4-DAY TRIAL AND PRESCRIPTION FOR SUCRAID®

Sucraid® Free 4-Day Trial (4DT)

Sucraid® 4DT offers eligible patients a short therapeutic trial of Sucraid® to assess response in patients clinically diagnosed with congenital sucrase-isomaltase deficiency (CSID). Eligible patients must reside in the United States, not previously been prescribed Sucraid® or been enrolled in the **Sucraid® 4DT** program, and be commercially-insured.* QOL Medical LLC reserves the right to modify or cancel the program at any time.

The 4DT Program is not available for federal healthcare program patients. To prescribe Sucraid® for federal healthcare program patients, please complete the Sucraid® 30-Day Prescription below on the right.

By signing below, prescriber agrees that s/he: has clinically diagnosed the patient with CSID; believes a therapeutic trial of Sucraid® is clinically appropriate for the patient; and will not charge any third party (including any insurer or patient) in connection with the **Sucraid® 4DT** program.

I authorize Optum Frontier Therapies to initiate the prior authorization process for the purpose of securing coverage from applicable healthcare plans.

Sucraid® Free 4-Day Trial

For older children and adults >15 kg, take 2 mL by mouth with every meal or snack up to 6 times per day.

☐ Dispense 1 Box with 25 single-use containers ONLY. **NO REFILLS**

To proceed with a Sucraid® 30-Day Prescription after 4DT confirmation or for federal healthcare program patients who are ineligible, please use the prescription box to the right. >

Sucraid® 30-Day Prescription

For older children and adults >15 kg, take 2 mL by mouth with every meal or snack up to 6 times per day.

☐ Dispense 180 single-use containers for a **30-day supply.**

Number of refills _____

Prescriber Signature:

Date:

Please attach a separate prescription if this section does not comply with your state's prescription law. Prescriptions from New York must be issued electronically.

5 PRESCRIBER INFORMATION

Prescriber First/Last Name:		NPI #:	
Collaborating Physician Name:*		NPI #:	
Facility Name:		State License #:	
Address:	City:	State:	Zip:
Phone:	Contact Email:		
Office Contact Name:	Office Contact Phone:	Office Contact Fax:	

NOTE: Original signature required - If required by applicable law, please attach copies of all prescriptions on official state prescription forms. *Collaborating physician name and NPI# only in applicable states

**This Program is not available for any patient who receives (or is eligible to receive) coverage or reimbursement (in full or in part) for medical treatment and/or prescription drugs through any federal health care program (including, but not limited to, Medicare, including Medicare Part D plans, Medicaid, State Children's Health Insurance Program (SCHIP), Veterans Administration health coverage, TRICARE or other Department of Defense health coverage, or the Puerto Rico Government Health Insurance Plan. Product dispensed under the Sucraid® 4-Day Trial Program may not be resold, charged to patients, or submitted for reimbursement to any payer, either directly or indirectly. Neither healthcare provider nor patient are obligated in any way to prescribe or purchase Sucraid®.*

Please complete and fax this prescription form to **1-866-850-9155**. Need Help? Frontier Therapies – Optum 1-833-800-0122

Sucraid® (sacrosidase) Oral Solution

FREE *INFANT* 4-DAY TRIAL AND PRESCRIPTION FORM | 4DT

1 PATIENT INFORMATION

First Name:	Address:
Last Name:	City:
DOB: / /	State:
Gender: ☐ Male ☐ Female	Zip:
Email:	Preferred Language:
Preferred Phone:	Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

2 INSURANCE INFORMATION

☐ Patient does not have insurance

Medical Insurance Name:		**Pharmacy Insurance Name:**
Phone:	Member ID #:	Phone: Pharmacy ID:
Policyholder Name & DOB: / /		BIN: PCN: Group#:

☐ **See secondary insurance information attached.** (**NOTE:** Be sure to include secondary insurance information when sending back these forms)

3 MEDICAL HISTORY (PLEASE INCLUDE ICD-10 CODE)

Diagnosis Code Category: ☐ Diagnosis ICD-10-CM **Code E74.31** ☐ Other Diagnosis: | Allergies: | Current Medications:

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I authorize Optum Frontier Therapies to initiate the prior authorization process for the purpose of securing coverage from applicable healthcare plans.

Sucraid® Free 4-Day Trial

For children ≤15 kg, take 1 mL by mouth with every meal or snack up to 8 times per day.

☐ Dispense 1 Box with 25 single-use containers ONLY. **NO REFILLS**

To proceed with a Sucraid® 30-Day Prescription after 4DT confirmation or for federal healthcare program patients who are ineligible, please use the prescription box to the right. >

Sucraid® 30-Day Prescription

For children ≤15 kg, take 1 mL by mouth with every meal or snack up to 8 times per day.

☐ Dispense 120 single-use containers for a **30-day supply.**

Number of refills _____

Prescriber Signature:

Date:

Please attach a separate prescription if this section does not comply with your state's prescription law. Prescriptions from New York must be issued electronically.

5 PRESCRIBER INFORMATION

Prescriber First/Last Name:		NPI #:	
Collaborating Physician Name:*		NPI #:	
Facility Name:		State License #:	
Address:	City:	State:	Zip:
Phone:	Contact Email:		
Office Contact Name:	Office Contact Phone:	Office Contact Fax:	

NOTE: Original signature required - If required by applicable law, please attach copies of all prescriptions on official state prescription forms. *Collaborating physician name and NPI# only in applicable states

**This Program is not available for any patient who receives (or is eligible to receive) coverage or reimbursement (in full or in part) for medical treatment and/or prescription drugs through any federal health care program (including, but not limited to, Medicare, including Medicare Part D plans, Medicaid, State Children's Health Insurance Program (SCHIP), Veterans Administration health coverage, TRICARE or other Department of Defense health coverage, or the Puerto Rico Government Health Insurance Plan. Product dispensed under the Sucraid® 4-Day Trial Program may not be resold, charged to patients, or submitted for reimbursement to any payer, either directly or indirectly. Neither healthcare provider nor patient are obligated in any way to prescribe or purchase Sucraid®.*